The JOURNAL *of the Oklahoma State Medical Association*

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IF "ORIENTAL FLU" SPREADS ACROSS the UNITED STATES

Editorials

House of Delegates Kicks Medicine's Laissez-Faire Policy Out the Door

By accepting the Welfare Department's proposal for the medical care of people in the four categories of dependency stipulated in Public Law 880, the House of Delegates has earned organized medicine a rightful place in the councils of men in matters concerning community health. We have acknowledged that social problems can be decided on their merits alone, and a "leave us alone" policy on our part can no longer be taken for granted.

Organized medicine has previously viewed with alarm any change that in any way threatened the status quo. It has been a "leave us alone" policy—a rear guard action. It has always been the same. It was so with Blue Cross. It was so with Blue Shield. A clear-cut example of this laissez-faire policy occurred in preparation of the recent all out campaign to vaccinate the population against polio. The problem was to immunize as many people as possible against polio. Medicine's answer in Oklahoma was conditioned by a desire to maintain the status quo. It should be done in the doctors' offices. The Health Department should be used only where absolutely necessary. Community clinics should be held only where they could not be avoided. Polio Foundation funds should not be used even though there was no money in hand to purchase vaccine for people over 19 who could not afford to pay.

This "leave us alone" policy of organized medicine has been an accepted and well-known characteristic. Problems could never be approached with an open mind. There was really never any point in asking us in. The people concerned already knew what our answer would be. Why ask us in at all? Sometimes they didn't bother to.

It is indeed refreshing to know that the House of Delegates did decide the present problem on its merits, and by doing so proved that it is possible for us to function effectively as a counseling body. The delegates decided that the fund provided by Public Law 880 is an additional subsistence but its use is restricted; that the old man who has worked hard all his life and the old lady who has kept house and raised her family can pay for the service that they expect to receive. To be unable to do so and to know that one will have to depend on the charity of the doctor and the hospital must be one of the nightmares of the aged. To deny them this is unthinkable even though it is a deviation from status quo.

I, too, fear the socialization of medicine. I believe that the best care is received by the man who selects a competent physician and pays for the service he gets. This is in effect what the Welfare Department is insuring, except that the funds are provided in the same manner as those for securing the other necessities of life for this group of people.

This is the first step of necessary developments in a society which accepts a mandatory retirement age. We are no longer agrarian people and town people with small shops. Many people who are and will be dependent on their social security checks will not have enough to provide for their medical and hospital needs. Although we will argue and fuss over this problem when it comes, I am confident now that this too will be decided on its merits, provided we secure a satisfactory administration of the program that has just been accepted.—BHN

Medical Care for Recipients Of Public Welfare

C. M. Bielstein, *Chairman Medical Care Recipients of Public Welfare Committee*

The action of the House of Delegates, in its meeting on July 21, 1957, in approving a resolution presented by Louis Ritzhaupt, M.D., would seem to necessitate a report to the members concerning this resolution.

The resolutions as presented and approved by the House was as follows:

Doctor Ritzhaupt moved that the House of Delegates of the Association express to the Oklahoma Public Welfare Department the desire of the Oklahoma State Medical Association to assist and cooperate with the Oklahoma Public Welfare Department in continuing adequate medical care to those on the State relief rolls and that the Association will approve the action as outlined by Doctor Bielstein as follows:

1. Recipients will have free choice of physicians.
2. All physicians will maintain the right to accept or reject welfare patients.
3. The program would be an in-patient and hospital care program in licensed general hospitals with admissions to be on a life in danger admission policy (the definition for this, the patient would have to be in such a medical condition that his life was actually in danger).
4. Authorization for admission would be for a period of seven days with reauthorization for another seven days possible under certain circumstances when life was still in danger.
5. Physicians to be paid on the basis of 75% of the Medicare Fee Schedule for surgery, and $5 a day for acute non-surgical conditions with a limit of ten days on each admission.
6. The Association not enter into a written contract with the Department of Public Welfare.
7. That in instances where a welfare recipient might have prepaid insurance, which would reimburse the physician in an amount greater than the schedule to be paid by the Department of Public Welfare, it shall be left to the physician which method of payment he will elect to accept, but in no instance accepting both.
8. In no instance will the obligation of the patient be discharged since this is considered a resource program and not an indemnity program.

The resolution and its adoption came as a result of the recommendation of the Sub-Committee on Medical Care to Public Welfare Recipients. This committee was appointed by the President as instructed by the House of Delegates at its special meeting on October 28, 1956. Its purpose was to advise and assist the Director of Public Welfare of the State of Oklahoma in developing a program of medical care for recipients of the Public Welfare Department.

The need for action on such a program came as a result of the passage of Public Law 880. This law allows for an amendment to the Social Security Act permitting states to earn matching funds up to $3.00 per month for each adult and $1.50 for each child on the public welfare rolls.

These funds could be used to develop a Medical Care Program at the state's own discretion and generally according to the individual state's plan. However, each state's plan necessarily had to conform to the basic principle of Public Law 880 and be given approval on such principle by the Department of Health, Education and Welfare.

The appointment of the committee began a series of preliminary studies seeking information which would make it possible to develop a program acceptable to all concerned.

The first and perhaps the most difficult item to decide was the most urgent "need" as it applied to the State of Oklahoma. The determination of this need was made necessary by the limit of the available funds and by the fact that the committee wished to support the spending of such funds in the manner that would give the recipients the best medical care available, and allow for some payment for services if desired, by those rendering the care. Results of a survey of need were not available because no such survey had been or has been made anywhere in the United States, to our knowledge. As a result of investigative work on the part of the committee as well as the representatives of the hospital group and the Public Welfare Department, it soon became apparent that the most urgent need, as applied to the subject in Oklahoma was that which presented itself when hospitalization became necessary. The Public Welfare recipients seemed capable of maintaining themselves adequately in so far as out patient care, nursing home care, convalescent facility care, etc.

During the preliminary studies, a great many facts and philosophies were discovered by the committee. The most important to us were:

1. Oklahoma with 465 out of each 1000 people over the age of 65 on Public Welfare rolls has a greater percentage of this age group who are recipients than any other state. The total, in this category, changes from month to month but reaches approximately 100,000. It is of interest that a major reason for such a large percentage is not necessarily poverty. A large percentage of these people voted for the tax that made it possible for a pension to be given them when they reached the age of 65, if their worldly goods were not sufficient to provide for them past

that age or any age after 65. These people feel, and rightly so, that they have paid their taxes and otherwise helped Oklahoma grow. They have considered the paying of the sales tax as an insurance or retirement fund and do not feel that it is more than is due them.

2. Once such a law is passed, there is no real choice as to whether or not a program is to be developed in a given state. The weight of opinion and pressure, political or otherwise, will force the adoption of same program. It was most apparent that such pressures were evident in so far as Oklahoma was and is concerned. The fact that some sort of program would be put into effect made it desirable that the Oklahoma State Medical Association have some part in the planning. This would help to channel the provisions of the program into the area of greatest need and would help prevent the program from coming under the control of those less capable of undertaking the dangers so inherent in federal subsidization.
3. There is no experience anywhere which can act as a guide toward predicting the number of recipients who will need care under such a program. While other states have had limited programs on a state basis, very few, if any, have had the available funds to even approach those which are now capable of being "earned" on a matching basis by the individual states. The only statistical figures available in Oklahoma that might apply to such a program are those which have been accumulated through operation of the Oklahoma Blue Cross plan. These statistics seem to indicate that as many as 33% of these recipients over the age of 65 might have some need for hospital care each year. If this proved to be true, the funds for each quarter would be exhausted long before the 120 days had passed. Therefore, it seemed mandatory that, at its onset, the Oklahoma program be rigidly restricted until sufficient time had passed to allow for actual experience to be gained. Thus it was decided that the program should be one which included medical and hospital care of those patients with a life endangering illness. It also seemed wise to restrict the allowable number of days for which hospitals could expect payment from the funds of this medical care program.
4. At its onset this program was to be considered as a service type program. This would mean that no funds other than those available under Public Law 880 could be used to defray the cost of medical care to the recipients. This presented an intolerable situation for obvious reasons. Late changes in the interpretation of the law changed the concept toward the idea that these funds were to be considered a resource to the recipient. This change allowed for the use of insurance, county funds, and funds from other sources. However, the recipient, who is considered by the law to be medically indigent, is precluded as a resource himself or herself. Of greatest importance to the medical profession was that this change allowed the individual physician to render his average fee and collect from the Public Welfare Department, private insurance, relatives, etc., but not from the recipient directly.
5. The adoption of a fee schedule presented a major problem at the onset of negotiation. It has long been the practice of local, state, and federal agencies to pay only token fees for service to the medical profession. This is becoming more and more intolerable for the reason that the average physician is giving more and more time toward necessary service from which he can exepct little or no reimbursement. Since such a practice conforms to the law of diminishing returns, there remains no choice for the physicians but to ultimately increase the cost of medical care to his private patients. Another reason that such token payments are unwise is that it never gives a clear picture of the true cost of good medical care. The members of congress who pass these laws need to know the true cost of such a program which is not subsidized by the medical profession. The problem of a fee schedule was made much easier upon the acceptance by the Public Welfare Department of the Medicare Fee Schedule as an average fee schedule for the State of Oklahoma. By this accept-

ance the Public Welfare Department could make payment for medical services on the basis of this average fee or a percentage thereof. Since the physician is rendering his individual average fee upon which he is allowed to make collections from other sources, it was possible for the committee to avoid the fixing of fees by anyone.

The committee's interpretation of the resolution passed by the House of Delegates is that those recommendations which we presented are approved, but that the House of Delegates wishes the committee to continue in its efforts to improve the principles and practices of the program. The committee will comply to the best of its ability, and it does not consider that the House of Delegates gave complete approval of endorsement to the program.

Council on Medical Service: Medical Care for The Indigent in 1957

In 1956, amendments to the Social Security Act authorized a new method of federal participation in state medical aid for recipients of public assistance. This new system will affect medical care problems in many states. The Council on Medical Service has, therefore, reviewed the pertinent legislation and the regulations, to the extent the latter have been established, in order to inform the states of the limitations and the possibilities of this program. The Council's Committee on Indigent Care, in December, 1956, compiled a series of questions and answers to explain these new amendments and to give a brief history of federal aid to indigent medical care in the United States and forwarded copies to state medical associations. This is a revision of the December draft, and, since federal regulations are not yet complete, this statement will probably be amended from time to time.

This series of questions has two basic sections: a description of the present system of care (effective until July 1, 1957), including definitions of public assistance and a brief history of this type of aid; and a description, so far as regulations have been established, of methods of financing care possible under the new amendments (after July 1, 1957).

Present Systems

Definitions

1. *Who are the "indigent"?*

The "indigent" or "needy" are those persons who cannot, through their own or their families' resources, provide for their basic needs—food, clothing, shelter, and medical care. They must have assistance from some other source to survive.

2. *Can "indigency" be measured by any national income standard?*

It would be very difficult to set up such a standard, because of differences in the cost of living in various areas of the nation. Standards would probably have to be varied to suit individual cities, counties, or states.

3. *What are the sources of medical care for the indigent?*

The three primary sources are (1) the physicians themselves, who provide much service without charge; (2) governmental assistance; and (3) private charities.

4. *How do the physicians provide indigent medical care?*

Physicians provide indigent care either through reducing their fees for those patients unable to meet the full costs of medical care or through providing care without any charge, both to office patients and to hospitalized patients in hospitals where the doctors are staff members.

5. *What does governmental assistance include?*

Governmental assistance includes both federally aided programs, such as care provided under the public assistance programs, and state-financed programs or community-financed assistance such as general assistance. Such specific programs as the Crippled Children's Commission, the Office of Vocational Rehabilitation, the Veterans Administration, and the Unemployment Compensation program, and all other programs which provide some form of publicly financed aid to the indigent, help, in some degree, in meeting costs of medical care (either directly or by payment to the client, who then purchases necessary medical aid directly).

6. *What do the private charity programs include?*

Private charity includes the work of the voluntary health organizations devoted to the study of specific diseases, local Community Chest agencies, such service organizations as the Lions and Rotary International (which sponsor health programs in particular areas), and such free care as is provided by the hospitals themselves and by private philanthropic organizations.

7. *With what sources of indigent medical care do the 1956 Social Security Amendments concern themselves?*

With public assistance programs only.

8. *What are the public assistance programs?*

These are the four programs authorized by the Social Security Act for which the state, if it decides to establish them, can obtain federal reimbursement of a portion of their costs; they are also known as "categorical assistance" programs.

9. *Why are they called "categorical assistance"?*

Because eligibility for these programs requires not only indigency, but also inclusion in a specific category of dependency. The four eligible categories are indicated by the program titles: Old Age Assistance, Aid to Dependent Children, Aid to the Blind, and Aid to the Permanently and Totally Disabled.

10. *How do these programs differ from the general assistance programs?*

General assistance programs provide aid for persons who are not eligible for one of the four public assistance categories, but who, nonetheless, need aid to subsist. Aid to such persons is, therefore, received from state and community funds, without any federal participation. Most "medical indigents" who receive governmental aid obtain it from such general assistance programs financed by the state and local community.

Background on Federal Assistance

11. *When did federal grants-in-aid become available to states for public assistance?*

In 1935, when the Social Security Act was passed. Federal grants-in-aid to states were offered in the specific categories of needy aged (OAA), needy dependent children (ADC), and needy blind (AB). In 1950, federal grants-in-aid were initiated for state programs for the permanently and totally disabled (APTD).

12. *Does general assistance receive any federal reimbursement?*

No; general assistance is financed entirely by state or local funds, or by a combination of the two.

13. *Who initiates and administers the public assistance programs?*

The state itself determines which programs it will sponsor and initiates these programs; administration is either at the state level or at the local level with state supervision. The federal government decides whether the state program meets federal specifications and, if so, reimburses part of the costs; it does not administer or initiate the program, nor does it decide which state agency or agencies will administer the programs.

14. *Can a county or municipality initiate an assistance program and secure federal reimbursement?*

No; plans must be submitted by the state and must be in effect in all its political subdivisions.

15. *What part does the federal government play in public assistance?*

The Department of Health, Education and Welfare is responsible for the administration of the four public assistance titles of the Social Security Act. These titles list the requirements states must fulfill if their public assistance programs are to be approved for federal reimbursement. The Department's Bureau of Public Assistance has issued and provided all states with a "Handbook" which interprets the federal laws and specifically outlines the requirements for program approval; revisions are also forwarded to all states as necessary. If a state plan fulfills these requirements, the Secretary of the Treasury reimburses the state on a quarterly basis for a portion of its public assistance expenditures in accordance with the formulas prescribed in the Social Security Act.

16. *How is the federal contribution determined?*

Federal contributions are based on the average monthly grant per person within a given public assistance program, within set per person maximum grants.

For example, under current legislation,

the maximum grant per person matchable for Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled is $60 per month. Federal aid is based on the amount paid out by the state within this limit. (If a recipient receives more than $60 in a month, only the $60 is counted in calculating federal reimbursement.)

Funds allocated, within this maximum, are averaged monthly and the federal goverment reimburses the state for 4/5 of the first $30 per person and ½ the remainder. Thus, if three OAA recipients received $75, $60, and $45, respectively, in a given month, the average would be based on $60 (instead of $75), $60, and $45, or an average monthly grant of $55 per recipient. Of this the state would receive $24 (4/5 x $30) plus $12.50 (½ x $25) per person.

For Aid to Dependent Children, the federal share is 14/17 of the first $17 of the average monthly payment per person plus ½ the balance; the maximums are $32 each for one dependent child and the adult responsible for his care and $23 for each addition dependent child in the same home.

For example, in three families, each consisting of a parent and one child and receiving state grants of $75, $64, and $25, respectively, federal participation would be based on $64 (instead of $75), $64, and $25, since the maximum matchable would be $32 per person or $64 for each family. These matchable portions of the grants average $51 per family or $25.50 per recipient, so the federal share would be $14 plus $4.25 per recipient of $36.50.

17. *If the grant to one state client is above the maximum matchable and that to another below the maximum matchable, are the grants averaged to determine federal participation?*

No; averaging is based only on the portion of the individual's grant within the federal maximums; if, with a $60 maximum, the state grants one client $75 and another $45, the federal aid is based on the average of $60 and $45 (as in the above example), not on $75 and $45.

18. *If the average grant per person exceeds the established maximum, is there any increase in federal grants?*

No; the federal grant is limited by the established maximums. State and local funds must be utilized without federal reimbursement to support recipient grants which exceed the federal matching maximums.

Present Medical Care for the Indigent

19. *Before the inauguration of the public assistance programs in 1935, how did the indigent obtain necessary medical care?*

Medical care was considered primarily a local or community responsibility, usually secondary to such other basic needs as food, clothing, and shelter. Medical care was provided either through community or state programs generally by county or city physicians, in county or city hospitals, and through the charity of local private physicians and hospitals.

20. *How did the public assistance programs affect the method of providing care?*

Within the set "matchable maximums," the states could include grants to public assistance recipients in ratio to their medical needs. The clients could use this grant to pay physicians, pharmacists, or hospitals for medical aid, and the state would receive federal reimbursement according to the established formulas. (However, receipt by the client of an additional state grant for medical needs did not guarantee that he would spend the money for that purpose.)

21. *Did the Social Security Act of 1935 allow states to receive federal reimbursement for money paid directly to physicians or hospitals for indigent medical care?*

No; under the 1935 act, all grants involving federal participation had to be paid directly to the assistance recipient himself, without restriction as to use. If states made direct payments to the "vendors" of medical care, these payments were not eligible for federal matching.

22. *How did the 1950 amendments to the act change this?*

The 1950 Social Security Act amendments allowed states to make payments for medical care "on behalf of" assistance recipients, without forfeiting federal reimbursement. This meant that the state could send a portion of an individual's grant to the physician or hospital which had provided care and still receive federal aid, within the matchable maximum set for that assistance program. (Direct payment by the state to phy-

sicians, hospitals, etc., the "vendors of medical care," is commonly known as "vendor payments for medical care.")

23. *Under these 1950 amendments, what methods could the state use to pay for indigent medical care and remain eligible for federal participation in the costs?*

The state could (1) continue sending the entire grant to the client, who would be expected to meet his own doctors' and hospital bills; (2) pay the physician or hospital directly with a portion of the client's grant; or (3) establish a "pooled fund" to pay medical costs for all clients of a given assistance program.

24. *What is the "pooled fund" system?*

In the pooled fund system, the state establishes a separate fund, to be used only for payment of medical costs for clients of a given assistance program. Into this fund, the state makes a set payment monthly for each person on the rolls of the program during that month; from the fund, medical costs can be met for any client of that program, without regard to the amount paid into the fund per person. The fund may be used for any type of medical costs, as the state decides, limited only by the size of the fund.

For example, if a state allots $5 per month from the grant for each person on Old Age Assistance rolls and there are 5,000 OAA clients, $25,000 is paid into the fund monthly. From this fund, the state can pay medical expenses for any OAA recipient without regard to the total amount paid into the fund from his grants; a recipient on the rolls only one month might receive care costing $200, while one on the rolls a year might need and receive care costing only $10. Thus, medical costs can be spread over the entire program and money can be expended as needed (within the limits of the fund) while federal reimbursement, on a 50-50 basis, remains proportional to the amount paid into the fund monthly. In addition, unexpended funds are carried forward from month to month.

25. *Prior to July, 1957, is the "pooled fund" separate from the basic public assistance program?*

No; it is merely a possible method of utilizing a portion of the individual's public assistance grant to spread the cost of medical care over the whole of a given program.

26. *Is the state required by the Social Security Act of 1935 or any subsequent amendments to confine its grants to those limits mentioned in the federal reimbursement formulas?*

No; federal "maximums matchable" and "matching formulas" indicate only the degree to which the federal government can reimburse the state for money expended for categorical assistance (whether in direct payments to the recipient or in payments made in his behalf for medical care). There is no limit placed on the funds the state itself may expend for clients of these programs.

1956 Amendments—New Financing Method for Medical Care

Legislative Basis

27. *What effect do the 1956 amendments to the Social Security Act have on medical care for the indigent?*

They establish a new method of financing medical care for clients of the four public assistance programs, distinct financially from the direct monetary assistance paid to the clients themselves. Each of the four public assistance programs is separately amended to allow the states to utilize this new method of financing to provide medical and "remedial" care for clients of that program, if the state so desires. The amendments, therefore, merely specify a new way of financing medical care; they do not establish a separate and distinct program of medical care.

28. *What is the purpose of these amendments?*

As stated in the amendments themselves (Title III, Sec. 300, Public Law 880, 84th Congress), "It is the purpose of this title (a) to promote the health of the nation by assisting States to extend and broaden their provisions for meeting the costs of medical care for persons eligible for public assistance by providing for separate matching of assistance expenditures for medical care . . ." (*Note:* the term "medical care," as used in the law, does not mean physicians' care only. See question 45.)

29. *When does this new method become effective?*

The new method goes into effect on July 1, 1957.

30. *What effect does this new method*

have on current methods of financing indigent medical care?

When the new method goes into effect on July 1, 1957, any vendor payment, to be eligible for federal reimbursement, must be made through this new system of financing. Public assistance, so far as federal participation is concerned, will be divided into two accounts: direct money grants to recipients and vendor payments for medical care.

31. *May the states still continue such other methods as vendor payment to physicians and hospitals from the individual recipient's grant?*

Yes, but such payments will not be eligible for federal participation. All public assistance monies, to be federally matched, must either be paid directly to the recipient or come under this new matching method.

32. *What does the new matching method provide financially?*

The new matching method provides that the federal government will reimburse the states for half the amount expended by the states for medical and "remedial" care, within the limits formulated in the amendments.

33. *What limits on federal reimbursement are set by these amendments?*

Federal participation applies only to an average monthly expenditure of $6 per adult client and $3 per dependent child. Thus, in calculating federal payment to the state, the federal share is half of any medical costs up to $6 (or $3) times the number of clients on the rolls during a given month. Any amount above this total expended on medical care in that month is not considered in determining the amount of federal aid.

For example, a state with 200 clients in an approved OAA program during a given month could spend up to $1,200 (200 x $6) on medical costs and still have federal matching on a 50-50 basis; any costs over and above $1,200 would not be considered in calculating the federal share. With 200 clients, state expenses of $1,200 would mean a $600 federal share; $2,000 from the state would still obtain only $600 federal reimbursement; $900 state expenditure would mean a $450 federal share.

The state may, however, establish or continue a pooled fund to equalize monthly fluctuations in medical care expenditures. Monies paid into such a fund during a given month will be used (in calculating the federal reimbursement) to determine medical costs rather than the actual vendor payments during that month. If a state's monthly payment into its pooled fund was $6 each for 200 OAA clients, the federal share would stabilize accordingly at $600 per month. The rate of expenditure from the fund would not affect the federal reimbursement. (See also question 48.)

34. *Does the size of the state's direct monetary grant to the recipient himself have any effect on these matching funds?*

No, the matching formula for medical care is completely independent of the public assistance rolls, so far as federal reimbursement is concerned. The only correlations are as follows: 1. In a given program, all those on the rolls of that program must also be eligible for the medical services provided. 2. The same agency is responsible for the direct assistance and the medical care program.

Administration

35. *Who established the medical care programs?*

Inauguration of such programs is entirely a state responsibility. The Bureau of Public Assistance has published a "Handbook" listing specifications which have to be met for federal participation; however, the state must itself decide to establish such a program, submit program plans, make the necessary appropriations and submit accounts to the Bureau of Public Assistance. The federal government itself has no authority to initiate or organize these programs.

36. *Who administers the programs?*

The state must perform or supervise all administrative functions and must establish its own regulations. Once the program has been approved, the federal government requires only that one agency be responsible and report for all phases of a given public assistance program, that separate accounts be presented for each public assistance program, in order that federal participation can be determined in accordance with the enabling legislation.

37. *Who, therefore, determines what medical benefits are to be provided?*

The state, except as limited by the specifications and standards issued by the fed-

eral government to the states as a guide in application for federal reimbursement.

Medical Benefits

38. *What medical care may be provided under this act, after July 1?*

This is a matter for the individual state to decide. The main limitation is that the same benefits, within the limits of available facilities, should be provided to all members of a covered program throughout the state. That is, a state could not provide hospitalization for OAA clients in one part of the state and not in another.

39. *Must payments be made in the same way throughout the state?*

No; fee schedules may be varied to suit local conditions or the state may use a prepayment plan in one section and direct payment of physicians or hospitals in another section. Benefits to welfare clients must be uniform, but methods of payment need not be.

40. *Must the state set up medical care programs for all public assistance clients?*

No; since the amendments are appended to the individual public assistance programs, the state may use this new matching method for one program, for all four, or for any combination of the four.

41. *Can general assistance clients or the medically indigent be covered?*

No, if these terms are used in the sense defined in questions 3 and 11, since these types of indigents are not covered by the provisions of the Social Security Act.

Note: A person may have all the qualifications for coverage under a public assistance program (e.g., Old Age Assistance) except the necessary degree of indigency and, therefore, be ineligible for a direct money grant. However, in case of illness, he might become eligible for public assistance for medical care only, and thus would come under the provisions of the medical care programs as a public assistance recipient.

42. *Does a state have to use this method of financing medical care for the indigent?*

No; a state may use whatever method it chooses. However, to obtain federal aid, a program must come under the provisions of this "6-and-3" method, as it is sometimes known. Any other method must be financed wholly from nonfederal sources, except inclusion of money payments for medical care in the direct grant to the client himself.

43. *Can a state make vendor payments from the individual client's basic grant?*

No; under the new amendments, all money grants in the basic public assistance program must be made directly to the client without restriction to be eligible for federal reimbursement.

44. *What type of medical benefits may be provided under this act?*

The amendments specify that the federal government may reimburse the state for sums expended "in the form of medical or any other type of remedial care (including expenditures for insurance premiums for such care or the cost thereof)."

45. *What does "medical care" include?*

The range and variety of medical services to be provided is decided by the individual state for each program; it need not provide the same benefits in two different public assistance programs. The extent of services provided is usually governed by the funds available and the need. Among services which can be provided are physician's care in the home, office, or hospital; hospital services; clinic or outpatient care; home nursing; convalescent and nursing home care; rehabilitation; drugs, prescriptions, and prosthetic appliances. Some states have even provided limited dental services, when a dental condition was adversely affecting the patient's health.

46. *What is meant by "remedial" care?*

"Remedial" care is used to indicate care by non-medical practitioners, such as Christian Science healers, in such states as recognize these practitioners and include them in the state's indigent care program.

47. *Must the state provide both physician and hospital services?*

The state decides which services are to be provided as part of the public assistance program, within the limits established in the "Handbook."

Changes Brought About by 1956 Amendments

48. *Have the new amendments affected the utility of "pooled fund" plans?*

Yes; after July 1, 1957, a "pooled fund" will be financially advantageous only to states whose per-recipient medical expenditures average below $6 some months and

above $6 in others (or $3 for dependent children). These states will be able to obtain a somewhat larger federal reimbursement through a pooled fund arrangement than they would using the simple monthly expenditure method of calculating costs. (e. g., a state which averaged $5 one month and $7 the next would receive $2.50 and $3 in federal money by the simple calculation; a $6 pooled fund payment would obtain $3 each month.)

However, states whose per recipient costs always average less than $6 per month or more than $6 per month would not gain financially. The former would receive the full 50% of its costs each month without a pooled fund; the latter would receive the maximum federal share of $3 per month per adult under either method.

49. *May funds for medical care of clients of two programs be combined?*

No; separate accounts must be kept for each program covered, and federal participation is based on the individual program, rather than on all four. Thus, all monies allocated for OAA must be spent on OAA clients only. However, for administrative purposes, federal regulations do not prohibit one agency's administering funds for all four programs, so long as the accounts are kept separately.

50. *How would this apply in the case of insurance coverage (allowed by the law)?*

It would probably mean that separate policy arrangements would be made for each program covered, in order to ensure separate accounts of premiums paid and benefits received for clients within each covered public assistance program.

51. *What is the purpose of this regulation?*

Each public assistance program was established by the Social Security Act as a distinct entity, so that the federal government requires that all OAA funds, for example, be used for OAA clients. Therefore, any method which allowed OAA funds to be utilized in another public assistance program would be disapproved.

52. *What primary qualifications should a state plan have?*

According to present interpretation, the plan must provide equal benefits to all those covered within a specific program, throughout the state; all clients of that particular public assistance program should be covered; a single agency must be responsible for both direct money grants to the client and the medical care program; and the medical aspects of the program should be under medical supervision.

Aside from this, the federal government attempts to give the state as much leeway as possible in suiting its plan to local needs and facilities.

Summary

The Social Security Amendments of 1956 establish a new method of financing medical care for clients of the four public assistance programs.

In this system, the federal government pays half the amount spent for medical care of public assistance recipients by a state within a quarter, up to maximum of $6 per month per client average for adults and $3 per month per client for children. Separate accounting is required for each public assistance program.

The same benefits must be provided for all clients within a given state program, but the methods of payment and fee schedules may differ in locally administered plans within the state. Plans are established and administered or supervised by state agencies, but each state's programs must meet the standards of the Bureau of Public Assistance of the Social Security Administration to be eligible for federal reimbursement. However, the bureau plans to leave its regulations flexible, so that the states may use the new matching method to improve their provision of medical care for the indigent.

The new matching method is effective July 1, 1957.

Note: The Bureau of Public Assistance will continue to formulate new regulations and make policy decisions concerning this matching method; further changes may be made. However, the preceding analysis is accurate insofar as essential information is available at present.

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Scientific Articles

STOP RHEUMATIC FEVER

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This is the slogan of your Oklahoma State Heart Association during its forthcoming year, and your interest is invited to the various activities and facilities of this Association. Beginning with this column, it will be the aim of the editors to review some of the problems in streptococcal infections, rheumatic fever, and rheumatic heart disease—all of which are intimately associated with the program to STOP RHEUMATIC FEVER. Many efforts are being made on the local as well as on the national medical scene in this campaign, and we shall hope to bring some of them to your attention. Your questions and inquiries concerning any details of the information in this and succeeding columns may be addressed to the Oklahoma State Heart Association, 825 N.E. 13th Street, Oklahoma City, and you may be assured that they will be answered.

There are many facets of the problem in STOPPING RHEUMATIC FEVER. While it is entirely clear that a preceding infection by a Group A beta-hemolytic streptococcus is necessary to produce rheumatic fever, there is a great gap in our knowledge as to why some individuals are more prone to streptococcal infections than others. Indeed, some authors have proposed that the offspring of two parents with rheumatic fever *must* receive antibiotic phophylaxis, because the risk of rheumatic fever and its serious sequel of heart disease is nearly 100%. Yet, on the other hand, even following *untreated* streptococcal infections, only about 3 to 5 per cent of individuals proceed to develop these complications. Hence, it is evident that there is a large void in our present knowledge between the relationship of the streptococcus to rheumatic fever and the likelihood that a given individual may contract the disease. We shall hope to explore some of these avenues in subsequent reports.

Another point that has received considerable attention in the medical literature has been the mass prescription of antibiotic prophylaxis against streptococcal infections as a deterrent to this serious sequel, rheumatic fever. The evidence is now shaping up quite clearly as to the pros and cons, and certain official bodies speaking for physicians and cardiologists at large have definite conclusions. This problem will be reviewed critically in future discussions.

Once rheumatic fever has occurred, however inadvertently, what can we do about it? Are there any forms of modern therapy from our vast pharmaceutical armamentarium that will in any way alleviate either the acute symptoms, abbreviate the duration of the acute episode, or prohibit some of the more severe complications of rheumatic fever, such as the serious forms of valvular heart disease? This too is a subject that has had considerable focus in medical writings, and we believe that there are several messages to be transcribed in this field.

But fundamental to all of these is the early recognition, diagnosis, and adequate therapy of a streptococcal infection in order to STOP RHEUMATIC FEVER. The current evidence for diagnosis on clinical grounds will be reviewed shortly in order that all physicians may be aware of the possibilities of making this diagnosis early without the aid of bacteriologic facilities. This will not only manage the problem of the patient at hand, but will in a larger public health sense tend to eradicate the offending organism from the patient earlier and hence reduce the possibility of spread to other susceptible hosts, who might be the ones most likely to develop rheumatic fever. All of the current diagnostic and therapeutic thinking will be reviewed in succeeding columns.

Rheumatic fever is a problem in Oklahoma today, as it has been for many years.

The funds of the Crippled Children's Commission are still needed to care for many of the children whose lives are marked by this unnecessary ailment. During the past year, there were 46 new cases of rheumatic fever reported to the State Health Department, and one may conclude that many more went unreported for various reasons. On the rolls of the Crippled Children's Commission are carried some 330 patients with rheumatic fever in its various forms and stages, and it is also fair to assume that many other patients, particularly adults, are not included in this number. The problem of rheumatic fever is with us in Oklahoma and will be with us until we are prepared to do something about it. We cannot deny any longer that the risk of an individual having rheumatic fever is greater than that of contracting poliomyelitis. All physicians in the state must join the crusade to STOP RHEUMATIC FEVER.

Finally, it should be pointed out that while the columns to follow will seem diverse in content, they all have one goal in common: STOP RHEUMATIC FEVER. The broader the dissemination of information is about the epidemiology, diagnosis, treatment, and prophylaxis of beta-hemolytic streptococcal infections, the sooner we may conquer streptococcal infections and prevent the crippled hearts as we are now conquering and preventing the infection that leads to the crippled legs of poliomyelitis.

This is the first in a series of articles prepared for The Journal *in cooperation with the Oklahoma State Heart Association.*

ALLERGY *and* EUERGY

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The attention of not only our state but of the entire nation is focused upon our celebration this year here in Oklahoma of the completion of our first half century of statehood. Preceding this by one year was a semicentennial date in medical history worth noting. The word allergy is now so commonly used by doctors and lay people that few realize that no such word existed prior to 1906. In that year a pediatrician named von Pirquet[1] coined the word is a combination of two others and means changed or altered reaction. This alteration in capacity to react results from exposure to an exciting agent and is manifested upon re-exposure to the same or to an immunologically related agent.[2] The substances most commonly thought of as producing such disturbed reactions are foods, house dust, molds, feather dust, animal danders, pollens, insects, drugs and sera. But exposure and re-exposure to these things does not produce this altered type of reaction in the majority of people. From our knowledge of immunology, we can assume that the cells and tissues of these persons do not fail to respond to such exposures but they do so in an orderly or undisturbed manner. Up to now we have had a name for the disturbed type of reaction but none for the orderly type. For my own usage I have adopted the term euergy for this normal type of reaction and I offer it for general consideration. People who do not suffer from allergy react in a euergic rather than an allergic manner. Preventive allergy attempts to guide the infant and young child away from the development of allergic reactions and to enable him to form his reactions in an euergic manner. Also our therapy is aimed at converting allergic reactions to the euergic type. It is my feeling that the word euergy, meaning a normal or undisturbed reaction, is just as useful as the word allergy which means an abnormal or disturbed reaction.

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Treatment of

CARDIAC ARRHYTHMIAS

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This paper was presented at the Annual Meeting of the Oklahoma State Medical Association on May 8, 1957, in Tulsa.

In the treatment of cardiac arrhythmias, the major point relates to the selection of a limited number of drugs; becoming well-versed in their indications and contra-indications; being familiar with the manifestations of the idiosyncrasies of each drug; knowing the minimum, therapeutic, and toxic doses, and the indications for the use of each preparation. Often, physicians attempt to use too many different preparations of the same drug. Frequently a set plan of therapy does not exist.

Simple paroxysmal atrial tachycardia, at times, will respond to simple mechanical and reflex producing measures (carotid sinus, oculocardiac and vagal stimulation). Paroxysmal atrial tachycardia in infants can be fatal. Lanataside—C (0.01—0.0125 mg. per pound) intravenously in a single injection may be life-saving. If the arrhythmia persists a second injection (one half the initial dose) can be repeated in thirty minutes.

Digitalis Preparations

Basically, two preparations are needed—one for fast action which is quickly eliminated, and a second which is slowly eliminated but requires several hours to become effective. Preparations which I prefer are Ouabain and Digitoxin.

Ouabain (Strophanthin G). A derivative of Strophanthus gratus, is available in 2 ml. ampules containing 0.5 mg., and is administered intravenously *ONLY*. This drug is recommended in urgent situations, where rapid digitalization (in 1-3 hours) is desirable and frequently may be life saving. Common examples are acute cardiac failure that occurs in labor of pregnancy, in post-operative surgical cases, and in certain arrhythmias of severe organic heart disease. A reduction in ventricular rate and venous pressure may occur within 5 minutes,[1] the maximum effect in 30 to 120 minutes, and the effects last from 24 to 72 hours.[2,3] The rapid elimination of Ouabain make it an unsatisfactory preparation for maintenance digitalis therapy. The therapeutic dose of Ouabain varies from 0.5 to 1.0 mg. When it is clearly established that no digitalis has been given previously, 0.5 mg. of Ouabain may be given intravenously over a 5 to 10 minute period. Contrary to general belief this interval allows for recirculation and fixation of the Ouabain in the heart muscle rather than an interval to observe for toxic results. Close observation of the patient and monitoring the heart rate with auscultation or with the electrocardiograph is indicated. This dose will digitalize a few patients and give significant relief to many. An increment of 0.25 mg. can be repeated in 30 to 120 minutes, as indicated by the clinical response. On occasion an additional dose of 0.25 mg. will be needed to obtain the desired result. Relief from dyspnea, diffuse rales, cold clammy sweat, and cyanosis, reduction of the heart rate, conversion of the arrhythmia and rise in the blood pressure are usually the most apparent signs of improvement of the patient's condition.

Most patients will require maintenance digitalis therapy. This can be started with the last dose of Ouabain. A slowly eliminated preparation such as digitoxin, digitalis leaf, etc., is desirable. Digitoxin 0.4 mg. orally (or, intravenously, if the oral route is not feasible) every six hours can be started until a digitalizing dose of 0.8 to 2.0 mg. has been given, depending upon the patient's size and sex. The patient then can

be placed on a maintenance dose of 0.05—0.15 mg. per day. Higher maintenance doses are not required except in *rare* instances. Digitoxin is discussed more in detail below.

An additional use for Ouabain: When, for example, a patient with atrial fibrillation with rapid ventricular rate presents himself, in whom the exact status of digitalis therapy is unknown (whether or not the patient is under—or over—digitalized), Ouabain 0.25 mg. can be given intravenously. If the apical rate drops, one can complete digitalization of the patient; if the apical rate remains the same or increases, the patient is already over-digitalized. The drug is excreted rapidly (within 8 to 36 hours) and toxic effects are of brief duration. Atrial fibrillation with a rapid ventricular rate can be a manifestation of digitalis intoxication. If over-digitalization is definitely suspected, the patient can be given 40 mEq, of potassium chloride diluted in 500 ml. of 5% dextrose in distilled water intravenously (run at 40 drops per minute). When the arrhythmia is a manifestation of digitalis intoxication, the rate will decrease significantly with obvious improvement in the patient's condition. Further digitalis for the time being is contra-indicated. If no improvement occurs, further digitalization can be undertaken.

Digitoxin: Digitoxin is a relatively pure crystalline digitalis glycoside of digitalis purpurea leaf obtained by hydrolysis of lanataside-A.[4] Digitoxin is completely absorbed from the intestinal tract. The oral and intravenous digitalization dose is the same.[5] Digitoxin is available in tablets of 0.05 mg., 0.1 mg., 0.15 mg., and 0.2 mg., and in ampules containing 0.2 mg. The initial effects are apparent in one hour, full effect in four hours, and dissipation requires two or three weeks. Apparent digitalis effect for as long as six weeks after discontinuing the drug has been reported.[6] The digitalizing dose varies from 0.8 to 1.5 mg. (rarely 2.0 mg.) in divided doses over a 24-hour period. The maintenance does varies from less than 0.05 mg. to 0.15 daily. *(Rarely does a patient require a maintenance dose of 0.2 mg. daily).* Digitoxin effect is uniform and practically predictable in its results. There is no nausea or vomiting in therapeutic doses since gastric irritation is not seen. The signs of over-dosage from this drug (listed in order of occurrence from early to extreme toxicity) are: those involving the central nervous system (vague headache, anorexia, sleeplessness, mental disturbances and neuralgias, nervousness, and scotomata or colored green or yellow vision), cardiac disturbances (premature ventricular beats frequently occurring in bigeminy, excessive slowing of the heart rate, prolonged conduction time (P-R interval), increased ventricular rate, occasionally complete atrioventricular heart block with an apex rate of near 40 per minute, paroxysms of atrial fibrillation, ventricular tachycardia and fibrillation, electrical and pulsus alternans and paroxysmal atrial tachycardia with or without a 2:1 block), later gastrointestinal symptoms (nausea, vomiting, and diarrhea), eosinophilia and possibly, thrombotic effects, at least experimentally. Allergic reactions have not been seen by this author, though reported.[7] These patients are over digitalized. White agrees with this opinion.[8]

I have not encountered untoward effects from the combined use of calcium and digitalis as has been reported.[9,10]

Quinidine Preparations

Quinine was introduced in 1927 for the treatment of cardiac arrhythmias by Wenckebach.[11] Quinidine is a dextrorotatory isomer of quinine and was introduced in 1918 by Frey.[12] Quinidine is more effective than quinine. Quinidine lengthens the refractory period, prolongs the conduction rate of both the atria and ventricles, increases the refractory period of the atrioventricular propagation and depresses the excitability of the atria more than the ventricles. The refractory period of the atria and ventricles is increased long before the conduction is prolonged.[13] This apparently accounts for the greater effect of quinidine in atrial compared to the ventricular arrhythmias. Quinidine is ordinarily contraindicated in patients with chronic heart disease. The prolongation of the refractory period that is produced by quinidine is directly opposite to the shortening of the refractory period produced by digitalis. Quinidine hastens the interruption of atrial fibrillation and digitalis fosters the arrhythmia. This does not deny the direct effect of digitalis on the A-V conduction resulting in the slowing of the

ventricular rate. Sokolow[14] recommends a dose of 0.4 Gm. every two hours. The dose can vary from 0.2 to 0.6 Gm. every 1 to 2 hours depending upon the urgency of the situation. Determination of serum concentration is the most accurate though impractical approach to the problem of quinidine therapy.[14,18] Successful conversion to sinus rhythm occurs in 82% of the patients with an average peak serum concentration of 5.9 mg. per liter; 75% convert at levels between 4 and 9 mg. per liter. These levels are obtainable with quinidine dose schedules of 0.4 to 0.6 Gm. every two hours for five doses.[14] Sedation, minimal activity and maintenance quinidine therapy are indicated for a period of observation to ascertain whether the arrhythmia will recur. One to 1.6 Gm. daily in divided doses will usually suffice in preventing immediate recurrences. The obvious desired effect of quinidine therapy is the abolition of the arrhythmia under treatment. The toxic symptoms are those of cinchonism, including tinnitus, impaired hearing, headache, nausea, mild diarrhea, and slight disturbance of vision in the mild cases.

In moderate cases, the former symptoms become more severe, color perception is altered, photophobia and diplopia and abdominal pain develop. The skin is hot and flushed and urticarial, macular, and papular eruptions occur. Fever, confusion and delirium may develop. In extreme cases, respiratory difficulty, cyanosis, cold sweat, tachycardia, atrial flutter and shock are seen.[8] The latter arrhythmias are less apt to occur if prior digitalization is given. Intraventricular block with widening of the QRS interval to 0.12 seconds or more, cardiac standstill and ventricular fibrillation has been reported from the depressant effect of quinidine. Sudden death is more apt to be due to cardiac asystole than to embolization because of the depressant effect on the sinoatrial and atrioventricular nodes. On the other hand, most deaths reported in the literature were predated by minor toxic symptoms or signs prior to the final dose of the medication. *This is important to keep in mind.* It appears therefore that some of these deaths could have been averted.

Idiosyncrasy, intolerance, toxic reactions including all the minor ones, such as drug fever, mild dermatitis, tinnitus, diarrhea, etc., occur in not more than two percent of the patients. *Quinidine is as safe as most drugs employed by the medical profession! Use it intelligently when indicated!* In my personal experience, I have not seen a death or major complication from quinidine. The custom of giving a test dose of quinidine for

TABLE 1.

SUMMARY of DRUGS for the TREATMENT of CARDIAC ARRHYTHMIAS

Drug	Route	Usual Dosage		Action		Indications	Contra-indications and Precautions
		Initial	Maintenence	Onset	Peak		
Ouabain	I.V. only	0.5 mg - 0.25 mg q. h. for 1-2 doses	Not for maintenence therapy	5-20 min.	½ - 1 hr.	Atrial flutter, fibrillation and tachycardia. Nodal tachycardia (severe acute congestive failure	Dilute to 5 ml, give slowly, monitor heart action with auscultation or ECG; avoid ventricular arrhythmias and previously digitalized patients.
Digitoxin	Oral or I.V.	0.8-1.5 mg in 24 hours	0.05-0.15 mg per day	Same for Oral and I.V. 1 hr.	4 hrs.	As Above	Digitalize patient with severe heart disease with atrial arrhythmias before using quinidine and procaine amide.
Quinidine Hydrochloride	I.M.	0.4-0.6 GM.	0.2-0.4 Gm. q. 1-2 hr.	10-15 min.	1 - 3 hr.	Atrial tachycardia, fibrillation and flutter; nodal and ventricular tachycardia; ventricular fibrillation.	I.M. is safer. I.V. may be life-saving. Monitor constantly with ECG. Observe minor toxic effects and re-evaluate patient cautiously.
	I.V.	0.6 Gm. in controlled I.V. drip		10-15 min.	½ - 1 hr.		
Quinidine Sulfate	Oral	0.4 Gm	Repeat q. 1-2 hrs. X 4-10 doses	30 min.	1 - 3 hr.	As above, and premature contractions	Observe patient before each dose; place on prophylactic therapy for period of observation; contra-indicated in Stokes Adams(cardiac asystole)
Procaine Amide	Oral	1 Gm.	0.5 - 1 Gm. q. 3-4 hr.	1 hr	2 hr	Ventricular tachycardia and fibrillation; nodal tachycardia; PVB with atrial tachycardia or fibrillation	Same for oral and I.V. quinidine
	I.M.	0.5 - 1.0 Gm. q.2-6 h.		½-1 hr	1-2 hr		
	I.V.	0.5 - 3.0 Gm. q.2-6 h.		½ hr	½-1 hr		

testing "sensitivity" is obsolete.

Quinidine Hydrochloride (for parenteral use): The parenteral use of quinidine is necessary in rare but occasional instances. These include atrial fibrillation, flutter, and tachycardia, and ventricular tachycardia and fibrillation complicating myocardial infarction and/or severe cardiac failure. The drug is available in ampules containing 0.18 Gm. (1.5 ml.) and 0.6 Gm. (5 ml.). The initial dose may vary between these. A maintenance dose of 0.18 Gm. intramuscularly every four hours is sufficient to prevent recurrence. Occasionally an intravenous drip containing 0.5 gm. is indicated in an attempt to quickly convert an arrhythmia. In these cases, I prefer to monitor the administration with constant electrocardiographic observations. When this is done, the drug can be interruped and maintenance therapy started when the arrhythmia is converted. When quinidine hydrochloride is given intramuscularly, it begins its effect in 10 to 15 minutes, reaches its peak effect in one to three hours and is almost entirely excreted in 8 to 24 hours. Intravenously, the drug is effective almost immediately, reaches its peak in one to two hours and is practically dissipated in 3 to 6 hours, although traces are apparent for 18 to 24 hours. Parenteral quinidine is not indicated for attempted conversion of long standing atrial fibrillation; in patients who have a known idiosyncrasy to cinchona or its derivatives; or in patients who have had a toxic reaction to previous minor doses. The patient under 40 years of age with paroxysmal atrial fibrillation, flutter of tachycardia without heart disease need not be pre-digitalized. Predigitalization prevents the ventricular rate from approaching the atrial rate existing before conversion (180-400 per minute, depending upon the arrhythmia being treated). Obviously, young patients with serious heart disease or elderly patients "without" heart disease must not be allowed to develop a ventricular rate approaching 300 per minute. The associated diminution of cardiac output and acute myocardial fatigue might quickly be fatal in a variety of ways.

Quinidine Sulfate: Quinidine sulfate orally should be used in most patients except where gastro-intestinal absorption is uncertain. Commonly there are instances where gastric suction is employed, when the patient is unconscious, or when the patient's condition is extremely critical. The drug is rapidly absorbed, the effect becoming apparent in 30 minutes, reaching therapeutic levels in one hour, persisting for 3 to 6 hours, and declining rapidly from the sixth to the eighteenth hour. The serum concentration studies[14,18] show an accumulative level when the drug is repeated at two-hour intervals. One hour intervals of the administration shorten the therapy period. Quinidine sulfate is available in 0.2 and 0.3 Gm. tablets and capsules. The recommended dose varies from 0.2 to 0.6 Gm. every hour for 3 to 5 doses or 0.2 to 0.6 Gm. every two hours for 4 to 10 doses.

Quinidine gluconate is likewise available and is satisfactory for intravenous use (0.8 Gm. in a 10 ml. stoppered bottle), but too dilute, in my opinion, for the intramuscular route. About three-fourths of the quinidine is destroyed in the body, and the larger part of the remainder is excreted in the urine.[19]

Procaine Amide: Procaine amide (Pronestyl) is a compound in which the ester linkage of procaine is replaced by an amide linkage. The pharmacologic actions are similar to those of procaine; however, the amide is more stable in the body and exerts anti-arrhythmic action in doses having little effect on the central nervous system.[20] The drug is almost immediately and completely absorbed from the intestinal tract and the peak effect is apparent within two hours.[20] With intramuscular injection peak action is reached in one hour.[21] The drug is dissipated at the rate of 10 to 15 percent per hour. Over half of the drug is excreted unchanged in the urine because plasma esterase (which catalyses the hydrolysis of procaine) does not act upon procaine amide. Procaine amide, like quinidine, lengthens the refractory period and prolongs the conduction rate of both the atria and ventricles and increases the refractory period of the atrioventricular propagation. However, quinidine increases the refractory period of the atria and ventricles long before conduction is prolonged, whereas procaine amide always causes deceleration of conduction as soon as it begins to lengthen the refractory period. This last point may explain the superiority of quinidine over the procaine amide in the

treatment of atrial fibrillation and atrial flutter. Both drugs depress exitability but quinidine acts more selectively on the atria while procaine amide is more effective on the ventricles. This fact may account for the better effect of procaine amide on ventricular arrhythmias.[13] The drug is available in 0.25 Gm. capsules for oral use and in 10 ml. stoppered bottles containing 1 Gm. for parenteral use. Parenterally the drug is given at the rate of 50 to 75 mg. per minute for a total dose of as much as 3 Gm.[22] The intramuscular route is safer and 0.5 to 1.0 Gm.[23] is used. Orally, the initial dose of 1 Gm. followed by 0.5 to 1 Gm. every 3 or 4 hours is suggested for most patients but a total daily dose of 10 Gms. may be required to convert an arrhythmia or to prevent recurrences. Ordinarily 3 to 6 Gm. per day is sufficient. If the desired effect has not been attained after 48 hours, the dose should be increased. The toxic effects involve the circulatory, gastro-intestinal, and central nervous systems. These include ventricular premature contractions, tachycardia and even fibrillation.[34,38] A 1:1 response to a supraventricular pacemaker is recorded in the treatment of atrial fibrillation and flutter. Cardiac asystole has been reported.[29,31] The former can be prevented in most instances by pre-digitalization. Atrio-ventricular block with Stokes-Adams syncope is a clear cut contra-indication to the use of procaine amide, just as in the case of quinidine. The blood pressure should be recorded frequently during administration of procaine amide because hypotension may result and vasopressor drugs (methoxamine, mephentermine and l-norepinephrine) may be required to counteract the effect. Some authors have suggested their concurrent use.[32] With oral administration of high doses, anorexia, nausea and vomiting may occur. Flushing and a metallic taste may occur with intravenous administration. Fever, chills, drug rash and agranulocytosis have been report-

TABLE 2.

Drugs of Choice in the Arrhythmias

Arrhythmia	Miscellaneous	Quinidine	Digitalis	Procaine Amide
Premature Contractions (a)	X	1	3	2
Atrial and nodal tachycardia (with organic heart disease)	Vagal Stim., etc.	1	2	3
		2 + 1 (or + 3)		
Atrial fibrillation and flutter: (with organic heart disease)	S E E B E L O #			
		2 + 1 (or + 3 ?)		
(without organic heart disease)		1	2	3
# P # with atrial tachycardia				1
# P # with atrial fibrillation				1
Ventricular Tachycardia (b)		2 (IV)		1 (IV)
Ventricular Fibrillation (b)	defibrillator	2 (IV)		1 (IV)
Complete A-V Heart Block (c)	Treatment rarely needed. Epinephrine 0.1-0.3 ml. subcutaneously or IV drip. Isuprel 5 - 15 mg. Pacemaker (?)			
Stokes - Adams (d)	Atropine sulfate 1-2 mg. Epinephrine 0.1-0.3 ml. intracardiac Pacemaker			

(a) includes atrial, nodal and ventricular origin
(b) requires constant monitoring with ECG
(c) first and second degree A-V heart block need not be treated, and
(d) when cause is ventricular fibrillation, use quinidine; when ventricular standstill, quinidine is contra-indicated.

ed.[33-38] Auditory and visual hallucinations and confusion is seen especially in the older patients. When decreased renal or cardiac function is present, the excretion of the unchanged procaine amide is prolonged and initial and maintenance dosage is less. As yet anaphylactic death due to procaine amide has not been reported in the literature. Intravenous barbiturates are specific therapy for anaphylactroid reactions. A history of sensitivity to procaine should serve as a contraindication to the use of procaine amide.

Procaine amide is indicated in ventricular tachycardia and fibrillation, nodal tachycardia and to a lesser degree, in atrial tachycardia, fibrillation and flutter. There is one notable exception to the latter reported recently by Herrmann, et al.[39] In patients with Wolff-Parkinson-White[40] (Bundle of Kent) conduction mechanisms, the electrocardiogram of atrial fibrillation resembles that of ventricular fibrillation and the electrocardiogram of atrial tachycardia resembles that of ventricular tachycardia. But the general condition of the patient is good (a pulse is palpable, blood pressure is present and heart sounds are audible). These respond to the intravenous administration of 0.5 Gm. of procaine amide, given slowly over a period of 15 minutes. In a few instances, a second dose was required. Quinidine had completely failed to convert these arrhythmias.[39]

Conclusions

Ouabain, a rapid acting digitalis preparation (acts in a few minutes) is suggested in the control or treatment of the rapid atrial and nodal arrhythmias when a delay of 4 to 6 hours might endanger life. Digitoxin is suggested for these arrhythmias when life is not in jeopardy. Digitalis in contraindicated in ventricular tachycardia and fibrillation. In adults, simple mechanical and reflex stimulation may convert paroxysmal atrial tachycardia. In infants, Lanataside-C intravenously may be life saving.

Summary

The merits of quinidine vs. procaine amide have been presented. The advantages, disadvantages and pharmacologic actions have been discussed. Procaine amide is distinctly indicated in atrial tachycardia with Wolf-Parkinson-White mechanism (pseudo-ventricular tachycardia). This condition should not be confused with true ventricular tachycardia. In atrial fibrillation with Wolff-Parkinson-White mechanism (pseudo-ventricular fibrillation) procaine amide is also the drug of choice. This latter should not be confused with ventricular fibrillation.

Both quinidine and procaine amide are contraindicated in Stokes-Adams attacks when these are due to cardiac asystole and of questionable value when the attacks are due to ventricular tachycardia or fibrillation. Isoprel (isoprel 1-norepinephrine) 15 mg. sublingual is indicated in the treatment of Stokes-Adams attacks with complete atrio-ventricular block.

Nodal tachycardia is extremely rare. Atrial tachycardia will frequently respond to carotid, oculocarotid or vagal stimulation or to other simple maneuvers.

It is wise to become fully familiar with a limited number of carefully chosen drugs rather than continue experimentation with a larger number equally limited in primary action.

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Therapeutic Conference

The PLACEBO

R. W. PAYNE, M.D., Moderator,

STEWART G. WOLF, M.D. and JAMES A. HAGANS, M.D.

Doctor Payne: The subject for discussion today is the placebo. This may seem a strange subject for a therapeutic conference, yet the neatly arranged house of the pharmacologist is considerably haunted by this rather boneless intruder. I must confess that I am not completely sold on this strange device, yet must admit that its prominence in the reputable literature is increasing by leaps and bounds. At least, evidence of certain remarkable properties of the placebo is becoming increasingly difficult to ignore.

The medical years 1935 to 1945 brought remarkable advances in antibiotic therapy. During the next decade emphasis was directed toward the development of the active hormonal therapeutic agents, such as the glucocorticoids, etc. Could it be that the present elucidation of the placebo will constitute Nobel Prize material? If so, I am sure that Doctor Wolf will be a strong candidate. I find myself increasingly aware of the fact that scientific study of the placebo is producing a tremendous impact upon medical therapeutics.

Dr. Stewart Wolf, Chairman of our Department of Medicine, is a pioneer in the study of the placebo and has contributed substantial knowledge toward our understanding of this subject. Dr. Jim Hagans, also a member of the Department of Medicine, is intimately concerned with analysis of the placebo effect in his extensive program of clinical therapeutic evaluation.

Doctor Wolf, I like to begin our discussions on some reminiscent phase of the subject. I wonder how your interest in placebos developed? How does one become interested in such an uninteresting subject? Could you give us a definition of the word "placebo"?

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Doctor Wolf: The reason I got interested in placebos was entirely accidental. We had been studying Tom, the patient with a hole in his stomach, before the war; and then for three and one-half years I was in the war separated from this fruitful experimental subject. Like so many veterans back from the war I had a good deal of anxiety about getting into production again. I elected to try a good many pharmacodynamic agents on Tom's stomach, recording their effects on gastric secretion, motility and on the state of the vessels in the mucosa. Among various agents, I gave him prostigmine several times. He hated prostigmine because it caused his mucosa to become intensely engorged with a marked increase in production of acid, which spilled out on his abdominal wall and burned the mucocutaneous junction. Prostigmine also caused intestinal cramps, frequently followed by diarrhea. Soon I noticed that no matter what agent I gave him, I would get the typical prostigmine-like effect. Even when I introduced just pain tap water into his stomach I noticed a very marked increase

of gastric function with the typical intestinal cramps. Then I made up a large red capsule filled with inert material, introduced this to him with: "Tom, I know you don't enjoy this but your participation in these studies is important because of your unique situation and I'm afraid we will have to go ahead with it," and popped this placebo capsule into his stomach. He had the most violent prostigmine-like response; gastric juice poured forth from his stomach and his abdonminal cramps became so intense that we had to terminate the experiment right away so that he could have a sudden bowel movement. This experience gave me respect for the placebo and also, of course, called for a redefinition of the term. Placebo, which comes from the Latin "I will please" is a name applied to inert agents given to people to please them. When placebos are effective they do much more than please the patient. They may also bring about the desired physiologic change which eliminates their symptoms. Undesirable physiologic changes might also be brought about and so it would seem convenient to extend the definition of placebo effect to include unfavorable as well as favorable effects. Thus, the placebo effect is any measurable physiologic change which occurs in response to administration of an agent which can not be attributed to any pharmacodynamic property of that agent. This means, of course, that active pharmacodynamic agents may have placebo effects in addition to their regular pharmacodynamic effects.

Doctor Payne: Doctor Hagans, what do you consider the most effective placebo? I have wondered why liquid placebos are so seldom used. Are therapeutic such as aspirin or vitamins considered good placebos?

Doctor Hagans: Well, that's a tough question for me to try to answer. The placebo could be, as you pointed out, in a liquid form; it could be injectable, or in several forms to be taken orally. I don't know the correct answer to your question, although, in general, judging from the satisfactory responses that one sees in practice from weekly or bi-weekly injections, I would suspect that injection is the most effective means of administering the agent. On the other hand, orally administered pink liquid phenobarbital, the contents of which are rarely known to the people who take it, seems to work pretty well (to say nothing of Lydia Pinkham's Vegetable Compound and Carter's Little Liver Pills). I don't really know the answer here, nor have I ever seen an objective study reported on that problem. I would guess that the "hypo" placebo would rate highest of all in a general study.

Doctor Wolf: Of course, one would prefer a placebo that the patient couldn't recognize and therefore a liquid would be a disadvantage, wouldn't it? Perhaps that is why capsules are usually the instruments of choice. Just trust people not to open the capsule.

Doctor Payne: Pharmacologists classify placebos as "pure" and "impure". There is some thought that any drug with pharmacologic activity is a relatively poor placebo. It is felt that such an agent is not a true placebo, or at least is "impure" in this regard. Aspirin, in particular, is condemned by the placebo purist. Has that been your experience, Doctor Wolf?

Doctor Wolf: Certainly many investigators complain about that and I think the point you make is an important one. Any pharmacodynamic agent can be used as a placebo as long as one knows what is does.

Doctor Payne: Perhaps the patient should not be mislead by any demonstrable effect of the agent. Doctor Hagans, if you were presented with a drug of vague pharmacologic effect, such as a new "tranquilizer," how would you set up a program to evaluate it?

Doctor Hagans: I think one of the essentials in evaluation of the effects of any drug in human beings (particulary if we are dealing with subjective responses rather than any objective measurements) is that we have available to include in our study program a record telling us to what degree other things may influence the responses that we are measuring. The common way to do this is to include a placebo agent which looks identically the same as the active agent that we are testing and supply it to the doctor who is going to carry out the tests under double-

blind conditions. This implies that neither the doctor nor the patient should know which bottle of tablets contains the active medicine and which bottle the placebo agent. The physician then sets about administering these tablets to various test-patients and records the results. This, at least theoretically, and I think practically, reduces any particular bias that the doctor or patient may have concerning that agent. At least (again theoretically) the same degree of bias would be present in the placebo bottle as in the other bottle of medication. Once the results are all in, the physician can measure the responses that occurred in the placebo group and compare them with the responses to the drug under study. Some of the results in such studies are quite amazing in that they are exactly the same. Often the doctor feels, during the course of the experiment, that he is getting a clear-cut drug effect and is quite surprised to learn he obtained the same effect with equal frequency in the placebo group. I have had such experiences on more than one occasion myself, in the testing of agents under the conditions of the placebo-double-blind.

Doctor Payne: I understand that a disconcerting problem in placebo studies is the so-called "placebo reactor." Such individuals, I understand, bear no distinguishing marks. For example, approximately 70 percent of a group of our medical students proved to be placebo reactors on one occasion. Medical students may not be entirely normal but they are usually rather astute observers. Doctor Wolf, how do you weed out the placebo reactor? How do you account for such an individual in controlled placebo studies such as the double-blind procedure?

Doctor Wolf: I think that the placebo reactor is like the motorist. Nearly all of us are motorists at one time or another and one couldn't possibly weed out the motorists in our population. The same would hold true for the placebo reactors. Whether or not one reacts to a placebo depends on many things, including conscious and unconscious associations and the manner in which an agent is given. For example, in a hospital in Massachusetts many of the staff men were reporting very favorable results with certain of the newer tranquilizing drugs. There were a few staff men on the other hand who were reporting poor results with the same drugs. A colleague simply took tab on all the patients and correlated therapeutic results, with a separate appraisal of the degree of positivity or negativity of the doctor's attitude toward the tranquilizers. He found a one to one correlation. The patients of the enthusiastic doctors did best. This is a rather striking demonstration of how people can be made to be placebo reactors, not because of something intrinsic in them but because of the circumstances under which an agent is given. Although the tranquilizing drugs are widely accepted in the treatment of disturbed psycotic patients, the only double-blind control study that I know about off hand, was reported in the October, 1955 issue of the *Journal of Mental and Nervous Diseases.* The authors were unable to distinguish the results between a placebo group and a group that received Chlorpromazine or reserpine at a dosage level of 350-800 mg. of Chlorpromazine daily and 850 mg. of reserpine daily. To return to the placebo reactor—Doctor Hagans has recently carried out a very ingenious study. I wonder if you would like to have him tell about that?

Doctor Hagans: I think most of the people in this room are aware of this study as many of them drank the ipecac. Essentially what we studied was a series of seven successive tests with antiemetic agents given to people who had nausea and vomiting induced by ipecac. During these seven tests there were times when each of the subjects took the active agents and times when they took placebos. We obtained no differences at all between any of the agents tested and the placebos. No matter how we analyzed the data, and we analyzed them in many different ways, the placebo action in each instance always seemed to be as good as that of the active agents. For practical purposes, then, we had seven placebo tests on the same individual. We analyzed these from the standpoint of searching for the person who would react to the placebo consistently in all seven tests. He would be a "placebo reactor." Presumably the person who would not react to any of the seven tests would be considered a pure "non-reactor." In order to compare

the results we obtained with some chance distribution we then took a coin and flipped it seven times in a row, counting heads as a "reactor" (a positive response to the placebo) and tails as a "non-reactor" (the negative). When we figured the incidence and classified them as heads and tails, or "reactors" consistently and "non-reactors" consistently we then compared the distribution in our experiment to the distribution in the coin test. If one just looked at the two graphs, I am sure that he could not pick out which one represented the therapeautic experiment and which one the coin tossing one. I think this simply establishes, as Doctor Wolf has pointed out, that at some time during the experiment everyone had reacted to the placebo and at some time almost everyone didn't. Further, there was no tendency for one individual to consistently react in a specific manner to a placebo even upon seven successive tests. The attempt, therefore, that has been recommended previously by some authors, namely to separate all people who have a tendency to react to a placebo would, under our circustances, have led to "weeding-out" a good many subjects, we believe, unjustifiably. The other aspect of that situation could be as follows: suppose we had a person who on the first three tests responded favorably to the placebo. We would then call him a "placebo reactor" on the basis of these three tests. We would anticipate that on the fourth test he would also respond to the placebo. Certainly a group of such people ("placebo reactors") should be more likely to respond than another group of people who have not responded at all on the first three tests. We analyzed the data from that standpoint and didn't find that to be true at all, so when all was said and done, the responses to the placebo that we observed appeared as though they were due to chance. At least, they had a distributon that was not distinguishable from the chance distribution set up by the tossing of a coin.

Doctor Payne: Doctor Wolf's and Doctor Hagans' findings on the placebo reactor are a little disheartening to me. If we are to use placebos in a considered manner it would be most convenient if we could anticipate those individuals most likely to respond to them. I don't think Doctor Beecher takes quite the same attitude. Though he believes that placebo reactors are essentially normal individuals, it is my impression that he feels that such individuals can be detected in some instances by psychological testing methods. Do you agree, Doctor Wolf?

Doctor Wolf: No, this represents a difference of opinion between Beecher's group and Lasagna in Baltimore, who feels as Beecher does, and our own group.

Doctor Payne: They say you can't fool children. What about placebo studies in children? Are there any such available?

Doctor Wolf: I don't know of any.

Doctor Payne: I suppose that these little individuals would present numerous complications in such a study.

Just recently an ethical placebo preparation has been made available. This is described rather glowingly as a pure placebo of prolonged action. The cost of these handsome capsules has been placed at a par with the usual price of a new drug. This has been done to strengthen the patient's faith in the efficacy of the corn starch. Probably the most pressing indication for such placebos is at the point where one is at a loss to know what to prescribe.

Doctor Wolf, what are the therapeutic indications for placebos? Could you tell us how they should be given and what type of preparation you would recommend? How long should they be given and how should they be discontinued? Might one expect withdrawal symptoms when these medications are discontinued?

Doctor Wolf: Let me start with the contraindications. One should not prescribe an agent as a substitute for coming to grips with the core of the patient's problem. If your patient's illness is dependent on his problems of adaptation to the people around him it behooves the doctor to get to know the patient and to deal with these problems of adaptation. He must not substitute any kind of pharmacodynamic therapy whether he intends to use its as a placebo or not. This is a very serious contraindication to the use of placebos. Of course this is the way in which vitamin B injections are used all over

the country. I hope this is something that the graduates of this school will not do. Now what about indications for the use of the placebo? I can give you one—a patient who came to me several years ago was taking enormous amounts of male hormone. He had been a P-T boat man in the Navy and had always been thought of as being extremely virile and active. When he got out from under the protective wing of the military and lived in the competitive society of New York he didn't feel quite so strong and virile, so he went to a doctor who naturally prescribed male hormones. Male hormones seemed to help so he took more and more of them and finally was taking them both parenterally and buccally in enormous amounts. The doctor who first prescribed the testosterone asked me to try to wean him away from it. Well, I started to wean him by substituting placebos. It took a long time but finally I was successful. This fellow is now an important person in his community. He is now addicted to the placebo. We at least cured the testicular atrophy which he had suffered from taking all that testosterone. We though it was very important to get him off it.

Any physician may temporarily give placebos to patients in the hope of getting a better grasp of the psychodynamic aspects of their patient's illness. I think it is usually pretty unsafe to explain to the patient that you have been giving him an inert substance when you discontinue the placebo and just let it go at that; as though whatever it was supposed to do is no longer required. With a few patients it is possible to explain exactly what you are trying to do, and indeed, in those individuals it is quite an advantage to explain it to them, but this is a little hazardous. I think, in short, that the administration of placebos should be undertaken for some good reason other than laziness and that they should never be used as a substitute for more definitive therapy.

Doctor Payne: It is reassuring to hear that. Some writers on the subject go to the extreme in maintaining that one should not use placebos for the treatment of relatively minor complaints, but should reserve them for the more serious diseases. I also understand that they should preferably be used in diseases that are not psychosomatic in origin. I find this all rather confusing. It would seem logical that they might be of value to circumvent the use of agents with adverse side effects; or to satisfy a patient's demand for treatment until adequate diagnostic procedures can be completed.

Doctor Wolf: Another indication of the placebos just occurred to me and I don't know whether this has been looked into very thoroughly. A few years ago Dr. Harrell Dodson and Dr. Howard Bennett studied the morphine requirements of post-operative patients. In some of these patients, instead of the routine order for opiates during the early post-operative period, they ordered sterile saline injections "ad lib." It was learned that the patients who received placebos instead of opiates noted no greater degree of suffering during early post-operative time than those who had received opiates. They had fewer gas pains and the interference of bowel function was much less troublesome than among the opiate group, as one might expect. Most of the patients in the placebo group seemed to value very highly the ready availability of an injection. It was not just the "shot" but the feeling that there was someone down at the end of the hall who would come when called. Beecher also did similar studies on post-operative patients and found essentially the same thing. It appears that much of the suffering and anguish that follows an ordinary routine surgical procedure comes from apprehension and anxiety. This can be alleviated by frequent injections or frequent ministrations of any kind and particularly by the knowledge that if you call for something you can get it. It seems to me that here is a very good place to use the placebo instead of the opiate.

Doctor Payne: I think that Dr. Harold Wolf has described the placebo as a symbol of comfort to the patient.

Doctor Wolf: Yes, I think that was his remark in one of the Cornell Therapeautic Conferences—a symbol of the availability of the doctors to help.

Doctor Payne: Certainly a humane consideration.

Doctor Hagans: Yes. I would like to express my feeling on that too. I don't know whether I am at odds with you two or not

on this point. Many times I have found a student, an intern, or a resident who has described a post-operative patient or a patient with a myocardial infarct, having pain, who is getting morphine and then, all of a sudden, for some reason or another, they decide that maybe the patient doesn't have any pain, and they try a sterile hypo and this works just as well as the morphine. The interpretation which is often put on this is that the patient really isn't having any pain. I would like to point out that this is the place where we have to keep our thinking quite clear. The fact that a sterile hypo did relieve the patient in no way means, at least to the best of our knowledge, that the patient wasn't having any pain or that the pain was of a purely psychogenic origin. As a matter of fact, one situation where the placebo seems to work best is for the relief of pain where it is most severe, and this is an interesting paradox. But the thing is that most analgesics, as well as the placebo, seem to work not at the affector organ where the pain originates, but rather in the conscious interpretation or reaction to to the pain that is received. I think it is very important to keep in mind, and not get hostile toward the patient and not feel that "Here is a paient who has been fooling me all the time and hasn't been haviny any pain." It is well to bear in mind that the patient is much more apt to respond favorably to the placebo if there is a good doctor-patient relationship, than if there is a poor one. When a patient responds favorably to a placebo, it is then, albeit indirectly, quite a compliment to the attending physician. He would do well to receive it and interpret it as such, rather than to accuse the patient of "fooling" him.

Doctor Payne: I think that is a very important consideration. These placebo reactors are not to be condemned, they are not mental defectives, they are not psychopaths, they are not hypochrondiacs; usually they are normal people and placebos may give them relief just as effectively as potent analgesics.

Doctor Wolf has been concerned with the toxicology of placebos. I find this most interesting and wonder if he will outline in brief the toxic effects he has encountered using placebos.

Doctor Wolf: This is an interesting point and I suppose it isn't unexpected, because if it is possible to produce bodily changes with placebos it is possible to relieve a physiologic mechanism productive of pain, as Doctor Hagans brought out. It would naturally also be expected that certain undesirable effects might be produced by the administration of a placebo. I think the most vivid experience that we have had with toxic effects of the placebo occurred in an experiment in which the so-called tranquilizing effect of Tolserol[R] was under study. We had a very elaborate double-blind arrangement for the study of objective and subjective evidences of anxiety and tension as affected by Tolserol[R]. We told the patients very little so that the whole procedure might have been somewhat frightening to them. We noticed a good many minor toxic symptoms, drowsiness on the one hand and sleeplessness on the other, anorexia, nausea and itching. These minor toxic effects occurred with precisely the same frequency in the placebo group as with the group who received the Tolserol[R]. Three of the placebo patients developed major toxic reactions. One of these was called dermatitis medicamentosa by the consulting dermatologist. This occurred on both placebo and Tolserol[R]. Another patient had an anaphylactoid reaction during which the blood pressure fell within ten minutes after taking the agent by mouth and there was an associated diarrhea. This reaction also followed the placebo. The third patient developed a giant urticarial reaction with swelling in the lower lip and tongue, following both the placebo and the active agent. I think this lesson is a very important one. When one is testing drugs one can't assume that the occurrence of toxic reactions is due to the pharmacodynamic or toxic properties of that drug. They may be due to other extraneous forces, including placebo effects.

Doctor Payne: Do you ever see the phenomenon of drug reinforcement or reduction in the side-effects of medications by concurrent administration of placebos? For example, can the nausea produced by morphine be prevented with placebos?

Doctor Wolf: I am sure it would work but I have never actually studied it.

Doctor Payne: This certainly would prove

a most complicated experiment. Doctor Hagans, will you tell us how prominent the placebo effect is among the multitude of "happiness pills" that are currently appearing on the drug shelves. I wonder if you would tell us of your experience with the drugs that might appear to be acting largely as placebos among these agents. In practice, how do you ascertain whether the drug you were giving is acting largely as a placebo?

Doctor Hagans: Those are fair questions and I wish I had a fair answer. I believe that it would be wrong to attempt to take the subject of feeling out of the doctor-patient relationships, and out of trying to give the patient the thing that helps and pleases him. The patient is better, and praises the doctor and the medicine for it, and I'm not sure even then that one should try to take these things out. But it is vitally necessary to recognize these phenomena and allow for their measurement. This is the magnitude, I believe, of the problem in trying to ascertain whether a therapeutic agent is working or not. The drugs that I have had the widest experience with have been the anti-hypertensive agents. There is no question that these agents can lower blood pressure sometimes and under some conditions. And there is very little question that certain of them in suitable doses will lower blood pressure rather dramatically most of the time. But upon sustained, chronic administration over a period of months there is considerable question, at least in my mind, as to whether any of the drugs can lead to satisfactory "control" of a person's blood pressure level. There is no question but that a large amount of the symptomatic relief which the patient who takes these drugs experiences is in the realm of placebo effect. This has been documented by double-blind studies on more than one occasion. Reiser, Brust and Ferris have contributed a large amount of understanding in this particular area. Anti-nauseant drugs represent an area that include some contradictory studies. In our studies we have attempted to grade results in terms of the way a clinical investigator, dealing with nausea and vomiting on the ward, would grade them; that is, complete relief (protection) and then partial relief (or marked improvement) in the nausea and vomiting experience. When we added this all together we found 65 to 75 percent effectiveness of the agents we tested. This was also true for placebo. There are very few placebo controlled reports on drugs intended for use in clinical nausea and vomiting, other than in motion sickness. There are very few of the reports that demonstrate any success rates with the drugs greater than these percentages. I wonder, although we do not have at our finger tips the information to prove this by our own personal experience, if we really have truly effective anti-nauseant and anti-emetic agents, other than for use in very specific circumstances, such as apomorphine intoxication.

Doctor Wolf: I would just like to comment on Doctor Hagans' percentages because I think there is a general point here. If you look over the literature you will find that roughly 2/3 of the patients are moderately or greatly improved and of this group something in the neighborhood of 20 percent greatly improved after almost any procedure be it pharmacodynamic, magical, or psychotherapeutic. This appears to be about the range of placebo action. The reports usually indicate that about a third of the patients are not benefited. This again raises the question "In the cure of disease, in the relief of the patient, what is man's part and what is nature's?"

Doctor Payne: Doctor Wolf, have you encountered any reports of fatalities from placebos?

Doctor Wolf: There has been at least one fatality, Doctor Payne. In the early trials of gamma globulin for poliomyelitis prevention, a fatality occurred within minutes after the injection of the material, which turned out to be a placebo. Now this isn't too surprising since 85 per cent of the persons who die from snake bite don't die from the venom but rather from the effects of the frightening situation. Most instances of drowning are not associated with water-logging of the lungs but are due to cardiac arrhythmias associated persumably with fright—so we'd expect an occasional fatality from the placebo.

Doctor Payne: Or in giving a placebo instead of active medication in the wrong situation. We appreciate this honest and stimulating discussion and I am sure that we have all gained respect for the placebo.

Case Report

VISCERAL LARVA MIGRANS

WALTER L. HONSKA, JR., M.D.

THE AUTHOR

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Introduction

Extreme eosinophilia may be found in many disorders. Allergic diseases, skin diseases, parasitic infestations, infections and diseases of hematopoietic system such as leukemia and Hodgkin's disease may be associated with eosinophilia. Certain disease entities produced by parasites infecting an abnormal host have recently been reported.[1] The larva of dog and cat ascarids of the genus Toxocara have been responsible for eosinophilia and granulomatous foci with or without larva in the liver, kidneys, heart, brain and lungs of children.[2]

Case Presentation

An 18 month old white male was admitted with a history of fever of 3 months' duration. The child was frequently seen eating dirt. Physical examination revealed an alert, vigorous white male in no distress. There were numerous firm anterior cervical nodes. The liver was 7 cms. below the right costal margin. The spleen was felt 3 cm. below the left costal margin. The remainder of the physical examination was unremarkable.

X-ray films of the heart and lungs were normal. The hemoglobin was 7.9 gms.; white blood cell count 26,600 with 10 neutrophils, 14 lymphocytes, 1 monocyte, 2 basophils and 73 eosinophils. Stools for ova and parasites were negative. The total serum protein was 9.9 gms. with albumin 5.5 gms. and globulin 4.4 gms. Cephalin flocculation at 24 hours was 1+. Bone marrow was normal cellular and no megakaryocytes were seen. Differential count revealed metamyelocytes 7; adult neutrophils 4; myelocytes 5; promyelocytes 3; myeloblasts 1; normoblast 36; eosinophils 30. Differential count of eosinophils revealed adult eosinophils 16; eosinophilic metamyelocytes 8; eosinophilic myelocytes 4; and eosinophilic promyelocytes 2. Laparotomy was done and exploration revealed many white nodules varying from 2 mm. to 10 mm. over the surface of the liver. Biopsy of liver was reported as: "Hepatitis, subacute (visceral larva migrans)" Fig. 1. The patient became asymptomatic on conservative treatment and was discharged from hospital care.

Discussion

Visceral larva migrans is usually found in children from 18 months to 4 years. There is a history of close contact with kittens or puppies and the child is usually known to eat dirt. Symptoms begin with loss of appetite, failure to gain weight, temperature elevation and cough. Urticaria and muscle pain is occasionally seen. Hepatomegaly is always present and spleenomegaly may be found. Convulsions have been reported.[2] Laboratory findings reveal eosinophilia from 20-80%. Hyperglobulinemia is freguently seen and stools are negative for ova, parasites and blood.

The disease is suspected in a child with appropriate animal contacts, hepatomegaly and eosinophilia. The diagnosis may be confirmed by finding characteristic granuloma on a liver biopsy.

The disease is usually self-limiting but eosinophilia may persist for months to many years. Treatment is symptomatic and attacking the larva with drugs has not been

satisfactory. Prevention is best obtained by frequent deworming of pets and not allowing children to play with young animals. Adult animals are usually immune to the Toxocara infection.[3]

Beaver was first to prove experimentally that the larva of nematodes naturally adapted to hosts other than man could remain immature in the human host for a long time and cause symptoms.[1] Brill in 1953 described autopsy findings in a 2 year old boy revealing granulomatous foci with eosinophilic infiltration in the liver, kidney, heart and lungs.[4] These allergic granuloma consist of disintegrating eosinophilic leukocytes and altered "fibrinoid" connective tissue. The adjacent tissue is infiltrated with many eosinophilis, many giant cells may be present and occasionally the larva may be seen.

The function of the eosinophilic leukocyte remains obscure. Well known for its presence in allergic response, their function in hypersensitivity is not understood. The cells increase in number following injection of foreign protein and during the decomposition of body protein. Therefore eosinophils may have some part to play in the disintegration and removal of protein.[5] A relationship with the adrenal gland exists since ACTH and Cortison depress the eosinophils.

Any abnormal parasite to man would be capable of causing this disorder; however, Toxocara canis is most frequently incrimenated due to the close relationship of man with kittens and puppies.

The normal hosts of Toxocara canis are dogs and cats. The eggs pass in excreta and contaminate the soil. In moist soil the eggs are ingested by dogs and cats and the larva hatch in the small intestine and migrate to the liver or lungs through the blood or lymph channels. They then reach the small intestine and mature to adults.[3] In man the life cycle is different since man is an abnormal host. In the abnormal host the larva hatch from the embryonated eggs and penetrate the mucosa of the small intestine to reach the liver, lungs or other organs and may remain alive for an undetermined amount of time. This may explain the persistance of the hepatmegaly and eosinophilis since in an abnormal host they are unable to mature to adults.

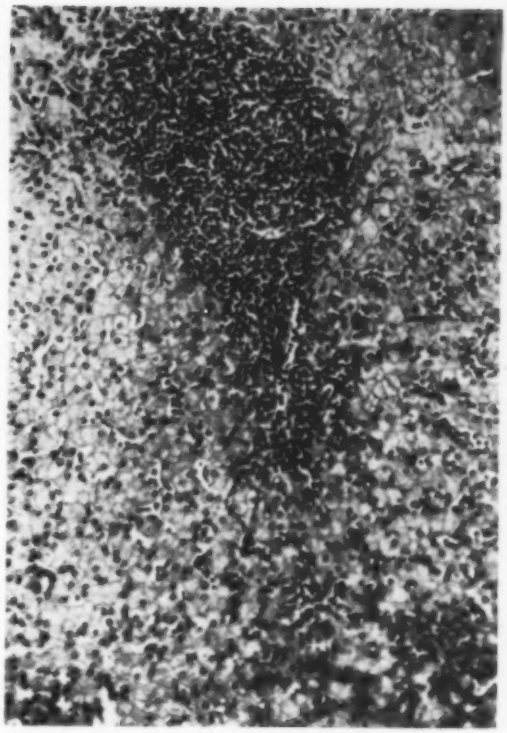

Figure 1. Section of liver showing a dense focal and diffuse infiltration of inflammatory cells, a large portion of which are eosinophils. A granuloma composed of foreign body giant cells is present.

Summary

A case of visceral larva migrans is described. Man's best friend may be the dog; but the puppy is not necessarily a child's best friend.

From the Department of Medicine and Pediatrics, University of Oklahoma School of Medicine and Medical Service, V.A. Hospital, Oklahoma City, Oklahoma.

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PRESIDENT'S LETTER

August in Oklahoma usually marks a letdown in all activities. The fairs and summer celebrations are mostly over, the crops are laid by, and those people who can are gone on vacation—those who can't are moving slowly and taking the weather in their stride.

It can also be a good time to make plans for the forthcoming autumn. It is to that thought I would like to call your attention. I should like to make an especial appeal to you in making your calendar of meetings for the Fall and Winter that you definitely set dates to attend your County Medical Society. Your County Medical Society is your organization. It can be most valuable to each and everyone of the doctors in Oklahoma. It is the organization where you, on a democratic basis, can express your views and ideas. It is the organization that you should work through in solving problems of community health. It is the forum you should avail yourself of in socio-economic policies in regulating some of medicine's every day problems. Membership in your county society is your immediate tie to organized medicine, Local, upward to District, State and National levels. Your participation is most vital in assisting your elected representatives in establishing policies and solving some of the complex problems that are developing in our country today. You will also find that as you meet and associate with your fellow practitioners you will become more tolerant and considerate, and some of the peculiarities of "the other fellow" will disappear upon your better acquaintance with him.

John Flack Barton, M.D.

President

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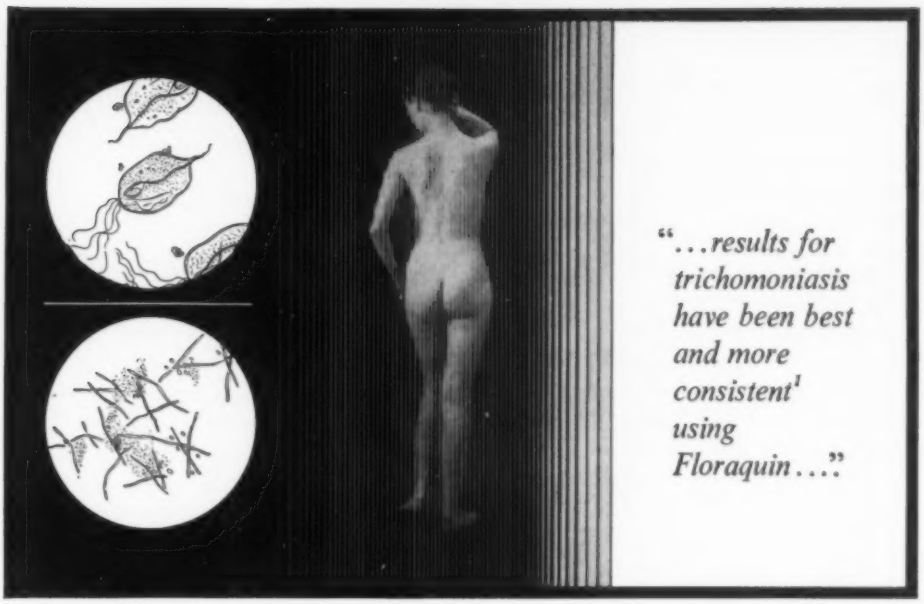

Floraquin® eliminates trichomonal and mycotic infection; restores normal vaginal acidity

Leukorrhea is by far the most frequent symptom of vaginitis; trichomonads and monilia are the most common causes. Many authors have reported[2] trichomonal protozoa in the vagina of 25 per cent of obstetric and gynecologic patients. Increased use of broad spectrum antibiotics has resulted in a sharp rise in the incidence of monilial infections.

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SEARLE

Association Activities

Asiatic Influenza Campaign Announced

Surgeon General Leroy E. Burney announced recently that first supplies of a vaccine against Asian influenza are expected to become available to the public during September.

Doctor Burney said the six manufacturers licensed to produce influenza vaccine have set production goal of at least 60 million cc. (doses) by February 1. This involves hiring additional personnel and operating two or three shifts, seven days a week.

The Public Health Service will undertake a vigorous campaign to urge maximum public use of the vaccine just as rapidly as supplies become available. The American Medical Association and the State and Territorial Health Officers will join in this effort.

Doctor Burney said he had asked the manufacturers to produce the vaccine as rapidly as possible. They have reported that they expect to have about 8 million cc. available by mid-September, including about 4 million cc. ordered by the military.

Doctor Burney noted it is quite possible, if not probable, that even with maximum use of the vaccine this country may have serious influenza epidemics in the fall and winter.

"There will not be enough time, of course, to produce and administer sufficient vaccine to immunize a majority of the population before the influenza season," he said. "But the vaccine is the only known preventive and we want to make the best use of it we can."

The Public Health Service, the American Medical Association, and the State and Territorial Health Officers are planning a cooperative public information and education campaign on the nature of the disease and steps to be taken in the event influenza strikes.

The American Medical Association, working closely with the Public Health Service, has developed a stand-by plan for the best use of available health asd medical manpower in time of an influenza emergency.

Asian influenza is caused by a new strain of influenza virus which caused widespread epidemics affecting millions of persons in the Far East last spring. The new vaccine is a monovalent or single strain type designed specifically to combat this Asian strain.

Because this virus is a new strain, Doctor Burney said, people have built no natural immunity to it. Thus it presents a special hazard. "We cannot be sure whether or when an epidemic may occur," Doctor Burney said, "but we should make all reasonable preparations."

There have been local outbreaks in the United States this summer, which normally is a season of low influenza incidence. Several thousand cases have been reported to date to the Public Health Service. Because of the nature of the disease—its swift onset and short duration—precise, up-to-the minute reports on incidence are difficult to obtain, Doctor Burney said.

Most areas of the country have probably been exposed to the virus by now and past experience suggests that the disease may suddenly begin to spread quite rapidly sometime in the fall or up through late winter, Doctor Burney said.

Doctor Burney pointed out that if epidemics should occur they could spread from San Francisco to Boston in a period as short as perhaps four weeks.

Cases of Asian influenza so far have been marked by temperatures of 102 to 104 degrees, headache, sore throat, cough and muscle aches. The fever lasts three to five days, followed by weakness for several more days. The attack rate in the Far East was approximately 20 percent with a death rate of about two-tenths of 1 percent.

Assuming an attack rate of 10 to 20 percent in this country, this would mean that in a city of one million persons, there could be 100,000 to 200,000 cases.

Past experience has indicated that a single injection of the vaccine will be about 70 percent effective. Protection develops in 10 to 14 days and lasts approximately one year.

The precise cost of the vaccine to the individual has not been determined. In bulk military orders the cost was 20 to 40 cents per cc. Retail prices, of course, may be somewhat higher. This price also does not include the cost of administering the vaccine.

As supplies become available to the public, the Public Health Service will recommend that particular consideration be given to the vaccination of those whose services are imperative for the care of the sick and those needed to maintain other essential functions.

The State and Territorial Health Officers and the American Medical Association have jointly assured the Surgeon General that community resources, both public and private, will be mobilized to provide vaccinations for persons who are unable to pay for such protection.

Doctor Burney said the Public Health Service has been in touch with the manufacturers of antibiotics, such as penicillin, and has recommended that they increase their supplies for the use in fighting secondary infections arising from a possible epidemic. The antibiotics can be used effectively to combat pneumonia or other diseases which may strike as an aftermath of influenza, although they have no value in fighting the influenza itself.

Early in the Far East epidemic the Asian influenza virus was isolated by U.S. Army medical teams and shipped to this country for analysis. On May 22, the Public Health Service sent prototype strains to licensed influenza vaccine manufacturers and work was begun immediately on the development of a vaccine against the new strain.

The Public Health Service continues to keep its epidemic intelligence services focused on influenza developments in this country and throughout the world, with particular attention to any indication of changing patterns in the severity or incidence of the disease. Clinical agents needed for diagnosis of Asian influenze are being produced and distributed, and Public Health Service laboratories are investigating acute respiratory diseases. In addition, the Service is testing and evaluating the vaccine.

THIS MONTH'S COVER

Jess D. Herrmann, M.D., F.A.C.S., whose picture is on our August cover, was elected President-Elect for 1957-58 of the American Academy of Neurological Surgery at the Annual Meeting held in November, 1956, at Camelback Inn, Phoenix, Arizona. Doctor Herrmann will be installed as president in November, 1957, at the annual meeting to be held at Sea Island, Georgia.

Doctor Herrmann was born in 1907 in Denison, Texas; he received his M.D. degree from the University of Oklahoma School of Medicine in 1931. Doctor Herrmann was certified in his specialty, Neurological Surgery, in 1940.

In addition to his membership in the American Academy of Neurological Surgery, Doctor Herrmann is a member of the Harvey Cushing Society, the American Medical Association, the Oklahoma State Medical Association, the Oklahoma County Medical Society. He is a Fellow, American College of Surgeons and a member of the Oklahoma City Academy of Medicine, the Doctors Dinner Club and Doctor's Luncheon Club. He also holds membership in the Alpha Omega Alpha honorary medical fraternity.

The Service will continue to keep the public and the medical and health professions informed on nationwide developments in the influenza picture and on the supply, distribution and use of vaccine.

So far, Asian influenze cases in this country have been confined to relatively small groups, in contrast with the Far East experience in which epidemics spread rapidly throughtout entire populations. States reporting some incidence of influenze are: California, Utah, Washington, Iowa, Kentucky, Louisiana, Pennsylvania, Rhode Island, New Mexico, Illinois, Minnesota and Connecticut.

The licensed influenza vaccine manufacturers are: Eli Lilly and Company, Indianapolis, Indiana; Lederle Laboratories, New York, New York; Merck, Sharp and Dohme, Inc., Philadelphia, Pennsylvania; National Drug Company, Philadelphia, Pennsylvania; Parke-Davis and Co., Detroit, Michigan; and Pitman-Moore Company, Indianapolis, Indiana.

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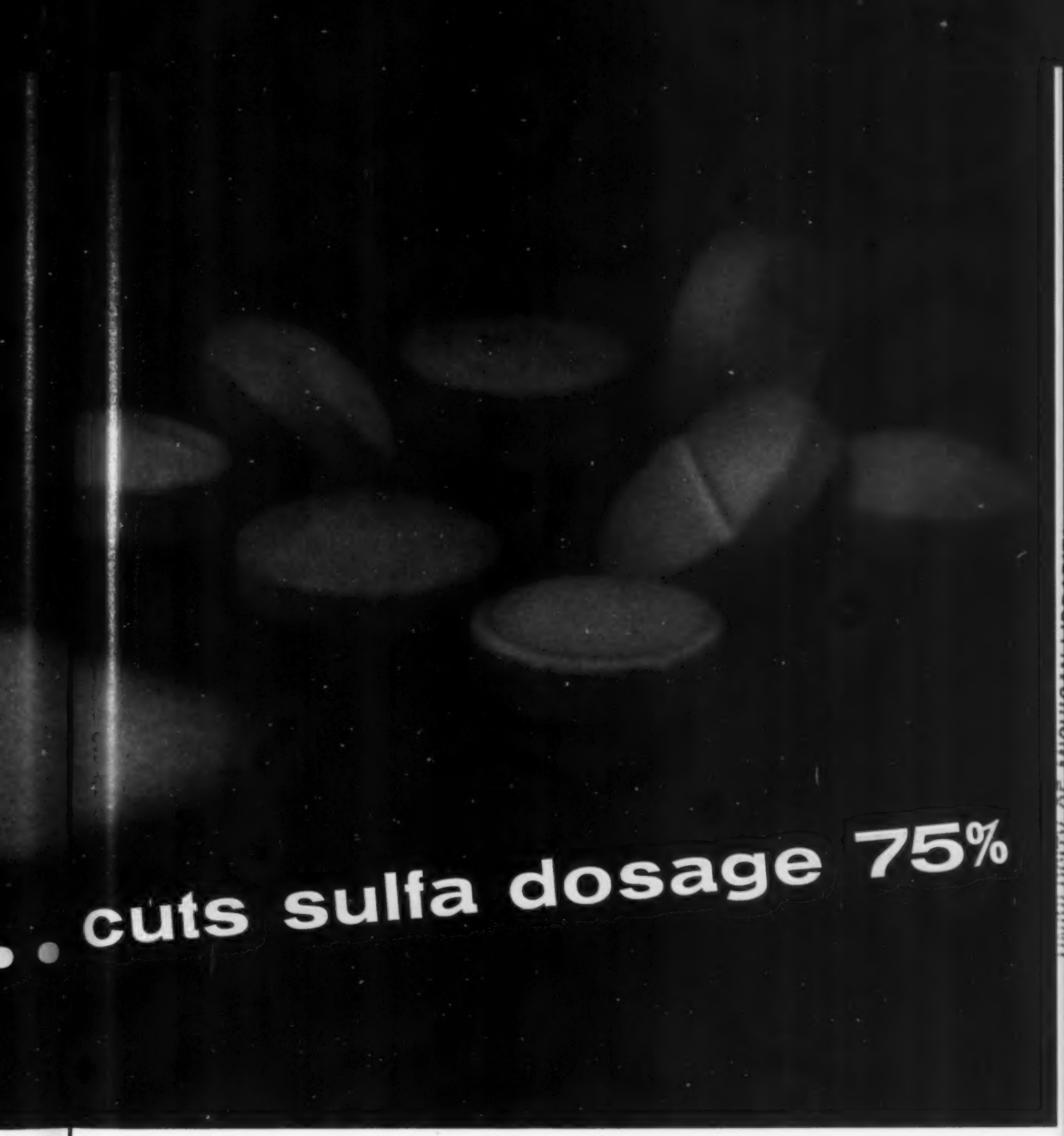

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(1) Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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Health Insurance For Federal Employees

There has been much speculation within the medical profession as to the manner in which federal employes might be covered for medical and hospital care. The following is a synopsis of the provisions of Senate Bill No. 2339 introduced by Senators Johnston of South Carolina and Carlson of Kansas.

This bill, which has the approval of the Administration, would authorize a contributory group health insurance program for federal civilian employees and their dependents (Federal Government to pay not more than one-third of the premium costs). Employees would select basic insurance coverage of their choice, but such plans must meet minimum standards. The Federal Government would contract for the purchase of catastrophic or major medical coverage. Employees would be required to take both basic and major coverage; they could not elect to take one or the other. The employee's contribution would be deducted from his pay.

It will be recalled the last year the Administration offered to furnish at no cost to employees major medical coverage with benefits starting after the employee paid the first several hundred dollars of expense. American Hospital Association and several federal employee unions voiced strong opposition to any plan which would not include basic coverage. This bill emerged as a compromise containing basic and major coverage, as approved by AHA in another proposal H.R. 7034. Some federal employee unions believe that the Federal Government should pay 50 percent of the total premium cost. The Administration's previous bill offering major medical insurance was proposed on the basis that empolyees earning $4,500 average annual wages would not need basic coverage and could afford the first several hundred dollars of medical expense. The Administration also contended that sixty or more percent of all civilian employees were already covered by basic health insurance.

The Civil Service Commission estimates the health program would cover approximately 1.8 million civilian federal workers. Another 2.7 million would be covered as dependents (60 percent of federal employees have dependents). The Commission estimates that the maximum cost to the Federal Government of participating in this program would be $64.5 million annually, $51.4 million of which would be for its contribution to basic health insurance and $13.1 million for its share of major medical coverage. The maximum total program cost (government plus employee contributions) would run approximately $200 million per year. The maximum federal contributions per capita would be $39.00 annually for an employee and his dependents and $19.50 annually for such an employee for major medical coverage (a total of $58.50 annually). The Commission estimates that the average cost per employee, counting those with dependents and those without, would run about $35.75 per year.

Synopsis of Veterans' Benefits Available

If you are interested in a brief resumé of the total scope of veterans' benefits, a summary has been printed at the request of the House Committee on Veterans' Affairs. The title is "Synopsis of Benefits Available to Veterans and Their Dependents, March 1, 1957," and requests should be addressed to Olin E. Teague, Chairman, Committee on Veterans' Affairs, House of Representatives, Washington, D.C.

The "Synopsis" contains, in very brief form a check-list showing what benefits are available to veterans of our four most recent wars, compensation and pensions rates, and brief description of educational, medical, loan, insurance, unemployment compensation and mustering-out payment programs for veterans. It is folded into a handy pocket-size, and makes a useful ready reference guide.

AFL-CIO To Fight Medical Society Actions

A firm stand against the actions of medical societies who fail to go along with union labor medical programs has been agreed upon by the AFL-CIO committee on social security according to the "Summer Newsletter" recently issued by the Association of Labor Health Administrators. The ALHA is a group of medical directors, lay administrators, and other representatives of union health center plans.

The publication calls for action in opposing the "attack and harassment of component medical societies against union plans, particularly in the states of Pennsylvania, Illinois and Colorado." It states that at a meeting on May 15 in Washington, D.C. "at the merged headquarters," the AFL-CIO executive committee approved funds to encourage and promote the work of the ALHA in providing "technical aid to the trade union groups in development of better health service programs for the benefit of workers and their families." The letter also stated that the association "will stand ready to bring experienced technical and legal counsel on request to the defense of the victims of any effort on the part of medical power groups to destroy programs which endeavor to improve the quality and scope of prepaid health services available to working people and their families." The work will be carried out in cooperation with AFL-CIO through its department of social security.

A.U.A Offers Urology Award

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been graduated not more than ten years, and to hospital internes and residents doing research work in Urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Roosevelt Hotel, New Orleans, Louisiana, April 28—May 1, 1958.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1957.

Cancer Society Elects Officers

Four officers were elected by the Board of Directors of the Oklahoma Division, American Cancer Society, at its mid-year meeting on June 15, 1957.

The officers who will serve two-year terms beginning September are Fred Boston, Enid automobile dealer, President; Mrs. E. Lee Ozbirn of Oklahoma City, Vice-President; William E. Eastland, M.D., Oklahoma City, Secretary; and W. Howard Patten, Norman banker, Treasurer.

The Executive Committee of the Board of Directors, which conducts the work of the Oklahoma Division between semi-annual meetings of the Board, names its own chairman, a physician, at its first meeting in September. The incumbent chairman is Austin H. Bell, M.D., Oklahoma City.

Other Oklahoma physicians who serve as a majority of the twenty-member Executive Committee and who were re-elected by the Board of Directors are: W. Pat Fite, Sr., Muskogee; J. W. Kelso, Oklahoma City; E. S. Lain, Oklahoma City; Ray H. Lindsey, Pauls Valley; John E. McDonald, Tulsa; Joe M. Parker, Oklahoma City; Ira O. Pollock, Oklahoma City; and Gregory E. Stanbro, Oklahoma City.

Members of the Oklahoma State Medical Association serve as chairmen of most of the American Cancer Society Division's standing Committees. These chairmen include Doctors Eastland, Parker, Lindsey, Fite, and Pollock and Harrell C. Dodson of Oklahoma City.

Open House Marks Completion of Clinic

An open house held March 16 celebrated the completion of the Ponca City Urological Clinic, pictured above, owned by Jack Alexander, M.D.

The structure is a modification of a former residence. A unique feature is that the main entrance is located at the rear of the building for the convenience of patients. The large parking lot is at the rear of the building.

Containing 1,400 square feet of floor space, the clinic has five rooms and is air conditioned. Included in the building are a waiting room and receptionist area, Doctor Alexander's private office, and x-ray room, treatment room and laboratory and bath.

Doctor Alexander, a native of Dallas, Texas, has been in Ponca City since 1953.

Have You Heard?

W. E. BOSWELL, M.D., Leedey, loaned a part of his interesting collection of saddles, guns and ammunition to be placed on public display in a downtown building in Leedey. The collection represents a part of a collection which has been gathered over a period of about twenty years.

A. H. HATHAWAY, M.D., of Mountain View retired recently from the active practice of medicine after serving the medical profession for 65 years. Doctor Hathaway has made his home in Mountain View since 1908.

PAUL HEERWAGEN, M.D., has retired from active practice at Collinsville to start his residency in general surgery at Hillcrest Medical Center in Tulsa.

A. H. ELLIS, M.D., who came to Pittsburg County in 1902, was honored by the town of Kiowa recently. Highlighting the celebration, which has become an annual event, was a barbeque to which all the physicians in the county were invited to be guests.

L. H. CHARNEY, M. D., Oklahoma City, received his certificate of Fellowship in the American College of Chest Physicians at the largest Annual Meeting in the history of the College. The meeting held in New York City registered 1884 physicians.

WILLIAM BEST THOMPSON, M.D., Oklahoma City physician and president of the Oklahoma Heart Association, spoke at the July meeting of the Maysville Rotary Club.

MELVIN ARTHURS, M.D., of Hinton, is being treated for bruises and internal injuries he received in a three-car collision occurring west of El Reno during the latter part of July.

J. RAYMOND STACY, M.D., of Oklahoma City was guest speaker at a clinical conference at the McAlester Clinic in May. Doctor Stacy spoke to the group of doctors on the rehabilitation of the injured.

C. S. HUNTINGTON, M.D., was guest speaker at the regular meeting of the Washington-Nowata County Medical Assistants Society held recently. Doctor Huntington's topic was "Hypertension."

M. L. WHITNEY, M.D., and C. A. CASHMAN, M.D., have opened a clinic in Okemah.

Auxiliary's Report of A.M.A. Annual Meeting

Attending the National American Medical Association Convention in New York City, June 2-7, was an inspiring and instructive post graduate course for me as well as the doctors.

I was pleased to give the Oklahoma report. Since we had just two minutes for each report, I choose one of our best projects, the "Future Nurses' Field Day" sponsored by Mrs. Clifford Bassett of Cushing. It was well received and several asked me for details after the meeting.

Our theme for the year "Health is a Joint Endeavor" was chosen by our National President Mrs. Paul Craig. It was Mrs. Craig's hope that the Woman's Auxiliary will extend homemaking in matters of health into community life, just as they practice it for their families.

Emphasis was also given to our "Handsome Investment"—our husbands. He and the family should have regular physical examinations. We usually take care of our children but neglect ourselves. Have you had a check-up recently? If not, why not make a date for one now?

Special roundtable discussions gave all the members an opportunity to pool experiences in working on legislation, public relations, organization, safety, mental health, civil defense and promotions of the various other projects that we study. We were asked especially to stress legislation and what part we could play in it. We feel that the doctor wants what is best for the patient. We hope to inform ourselves and help educate the public, try to meet our legislators and politicians and get them to give us their ideas and let them hear ours.

I liked the Princeton project discussion "How to Promote Capitalism." In my opinion, it is time someone did. We all say we believe in free enterprise—isn't it the same thing?

I am certain that if the doctors could be present at any of the Auxiliary meetings, they would insist that their wives be active members. Bring your wife to the next National Meeting and suggest that she come as a Delegate. I can promise you that her work in Auxiliary will be of benefit to you and your profession.

—Mrs. John Powers Wolff, President
Oklahoma State Medical Auxiliary

Small Business Loans to Health Facilities Near $3 Million Mark

In connection with the loan activities of Small Business Administration, the Senate Banking Committee recently favorably reported a bill to extend the agency another year beyond this July 31. It also would increase its loan authority by another $75 million bringing the loan fund to $305 million. Dr. David Allman, President of the American Medical Association, suggested to the SBA last fall that if it were going to make loans to group practice physicians, it should also include solo practitioners.

The SBA, reporting its loan activities in the health field, estimated that it had made 34 loans totalling $2,976,550 for construction, expansion or equipping health facilities. Loans were made to proprietary hospitals, nursing homes, medical and dental laboratories and one combined medical-surgical-dental clinic. Money is loaned either directly to the borrower or in participation with a bank. The total covers the period between last October and July 1 of this year.

Several applications are pending in regional offices for loans direct to physicians. They and other professional people are now eligible for SBA loans. The prospective borrowers seek funds for construction, expansion or improvement of offices, and for purchase of office equipment.

SBA decided last fall to enter the medical field and to offer loans to proprietary facilities, including group practice clinics. The American Medical Association then suggested that if loans were to be made in this field, they also should be available to doctors in solo practice. SBA went ahead with loans to hospitals and nursing homes, but, not certain it had enough funds to offer loans to professional persons, SBA delayed until recently on individual loans. Details may be obtained at regional offices in Boston, New York, Philadelphia, Richmond, Atlanta, Cleveland, Detroit, Chicago, Minneapolis, Kansas City, Dallas, Denver, Los Angeles, San Francisco and Seattle.

MALCOM E. PHELPS, M.D., El Reno, presents an honorary citizenship to Oklahoma to Secretary of Defense Charles Wilson and Mrs. Wilson. The presentation was made at Ft. McNair in Washington, D.C., when Doctor Phelps attended a national Medicare Committee meeting of which committee he is a member. Doctor Phelps also presented a certificate of Honorary Citizenship to Assistant Secreary of Defense Berry.

Twenty-Seventh Annual Fall Conference of Oklahoma City Clinical Society Scheduled for October 28, 1957 at Biltmore Hotel

The Oklahoma City Clinical Society will open it's twenty-seventh annual three day conference at the Biltmore Hotel on October 28, 1957.

An outstanding program of postgraduate teaching has been arranged. This includes lectures and discussion by fifteen distinguished guest speakers selected from various medical and teaching centers throughout the nation. In addition to the general assemblies there will be specialty lectures, a clinical pathologic conference, and daily luncheon roundtable question and answer sessions.

The entertainment will include a banquet on Monday evening at which time the Oklahoma County Medical Society will be host to the guest lecturers and out-of-town doctors. Kenneth McFarland, Ph.D., of Topeka, Kansas, nationally known lecturer and entertainer will be the principal speaker at this banquet. On Tuesday evening, there will be a social hour followed by nine specialty group dinners, and on Wednesday evening, to climax the three day conference, the annual dinner-dance sponsored by the Oklahoma City Chamber of Commerce will be held.

The Conference has been approved for credit under category I by the American

(Continued on Page 408)

A.M.A. Announces Two Changes In Administrative Setup

The American Medical Association recently announced two important changes in its administrative setup.

The Board of Trustees elevated Dr. George F. Lull of Chicago, who has been secretary-general manager of the Association for 11 years, to the newly-created position of assistant to the president of the A.M.A. He will continue serving as secretary, which is an elective office.

At the same time, the Board announced the appointment of Dr. J. F. L. Blasingame of Wharton, Texas, to the position of general manager of the American Medical Association. He will take over his new duties on January 1, 1958.

Doctor Blassingame, who is 50, has been active in medical affairs, both at the state and national level, for many years. When the A.M.A. House of Delegates elected him as a member of the Board of Trustees in 1949 he was one of the youngest physicians ever chosen. Since then, he has held many important A.M.A. committee appointments.

He served as president of the Texas State Medical Association in 1955.

Teaching and medical education have always been close to his heart. After graduating from the University of Texas Medical School at Galveston in 1928, he spent three years as a teacher on the medical school staff. Ever since then he has maintained a teaching connection at the University of Texas.

Dr. Edwin S. Hamilton, Kankakee, Illinois, chairman of the A.M.A. Board of Trustees, said that the "164,000 members of the American Medical Association are fortunate in obtaining the services of Doctor Blasingame. He is young, highly experienced, and he is making the change at a great sacrifice to himself."

Doctor Hamilton, in announcing the appointment, said that "Doctor Blasingame is dedicated to the principles of good medical care for all of the American people. He possesses all the essentials of leadership, plus knowledge, imagination and sound thinking. His work on behalf of medicine through the years has shown that he has the courage and initiative to shoulder responsibility."

Dr. Lull to Assist President

In his new job, Doctor Lull will relieve the president of the Association of many of the burdens of this office, which have become especially heavy in the last few years.

Doctor Hamilton said that "Doctor Lull will serve as spokesman, trouble-shooter, listening post, information center and as an ambassador of the medical profession in cities and towns throughout the country. His experiesce is invaluable, and it will be applied in solving medical problems at the state and local level, as well as nationally."

Doctor Lull, who is 70, joined the A.M.A. staff after serving 34 years in the Army. He entered the Army in 1912 as first lieutenant, emerging as major general of the Army Medical Corps. His last position before retirement was deputy surgeon general of the Army.

Doctor Lull received many honors in cosnection with his Army service during both World Wars, including the Distinguished Service Medal. In 1951, the Cuban government gave him its highest honor: the Order of Carlos Findlay for his humanitarian work in the field of medicine.

Dr. Blasingame to Move to Chicago

In discussing his new post, Doctor Blasingame said that he will leave his private practice which he has carried on in the same location for 20 years, and will move his family to Chicago, where the A.M.A. headquarters office is located, as soon as possible.

Doctor Blasingame has five children—three daughters, 22, 20 and 13, and two sons, 17 and 10.

His 20-year-old daughter, Betty, will soon enter the University of Texas Medical School; his 17-year-old son, John Chester, is a pre-medical student at the University of Texas in Austin.

Doctor Blasingame has long been active

in civic affairs not only in his home town, but throughout Texas.

He is president of the Blue Cross-Blue Shield Plans of Texas; he is chairman of the Board of Trustees of Wharton County Junior College, and he is also chairman of the medical advisory board of Sears, Roebuck Foundation, which encourages young doctors to create new medical facilities where they are needed.

Doctor Blasingame's many activities took his away from home 128 days last year, and he traveled more than 60,000 miles, mostly by air.

Physicians who know him will say that he posesses a preciseness of manner and a diplomatic polish that compliment each other in both his role as a practicing physician and as a spokesman for his colleagues in state, national and international groups. He has represented the A.M.A. at several world conferences of the World Medical Association abroad.

Oklahoma City Clinical 27th Annual Conference

(Continued from Page 406)

Academy of General Practice. Registration fee for Association Members is $20.00 which includes all features of the meeting.

The Clinical Society officers are: Herman Fagin, M.D., President; Charles Hugh Wilson, M.D., Director of Clinics; Ralph A. Smith, M.D., Vice-President; Vernon D. Cushing, M.D., Secretary; and Thomas C. Points, M.D., Treasurer.

A cordial invitation is extended to all physicians who are members of their County Medical Societies to attend this meeting from October 28th through October 30th.

Guest speakers scheduled to appear on the program are:

Harry E. Bacon, M.D., Philadelphia, Pa. Professor and Head, Dept. of Rectal and Colonic Surgery, Temple University; David M. Posworth, M.D., Professor and Director Orthopedic Surgery New York Polyclinic Graduate Medical School and Hospital, New York City; Carlton B. Chapman, M.D., University of Texas Southwestern Medical School, Professor of Medicine, University of Texas Southwestern Medical School, Dallas, Tex.; Frank C. Coleman, M.D., Ass't. Clinical Professor, Dept. of Pathology, University of Nebraska College of Medicine, Omaha, Nebraska; Edmond L. Cooper, M.D., Instructor in Ophthalmology, Wayne University College of Medicine, Detroit, Mich.; James L. Dennis, M.D., Medical Director of Children's Hospital of the East Bay, Oakland, Calif.; James E. Eckenhoff, M.D., Prof. of Anesthesiology, University of Pennsylvania School of Medicine, Philadelphia, Pa.; Isadore Lampe, M.D., Prof. of Radiology, University of Mechigan Medical School, Ann Arbor, Mich.; Milton L. McCall, M.D., Professor and Head, Dept. of Ob & Gyn., Louisiana State University School of Medicine, New Orleans, La.; Edmund R. Novak, M.D., Instructor in Gynecology at Johns Hopkins Hospital, Baltimore, Maryland; Rees B. Rees, M.D., Assoc. Clinical Professor and Chairman of the Sub-Department of Dermatology, University of California School of Medicine, San Francisco, Calif.; Harry W. Southwick, M.D., Assoc. Professor of Surgery, University of Illinois College of Medicine, Chicago, Ill.; Homer Swanson, M.D., Assoc. Professor in (Neurological) Surgery, Emory University Medical School, Atlanta, Ga.; Theodore E. Walsh, M.D., Professor and Head, Dept. of Otolaryngology, Washington University School of Medicine, St. Louis, Mo.; Austin S. Weisberger, M.D., Assoc. Professor of Medicine, Western Reserve University School of Medicine, Cleveland; Kenneth McFarland, Ph.D., Nationally Known Lecturer and Entertainer, Educational Consultant and Lecturer for General Motors Corp. and Educational Consultant for American Trucking Associations, Inc.

For further information write executive secretary, 503 Medical Arts Bldg., Oklahoma City.

Disability Income Available Under NSLI

Four out of five doctors do not have disability income on their National Service Life Insurance

A recent survey of close to 100 members of the Oklahoma State Medical Association disclosed the fact that close to four out of five doctors who own National Service Life Insurance of the participating type had not realized that a non-cancellable disability income provision can be added to such insurance, subject to a medical examination.

In addition to waiver of premium in the event of and permanent disability occurring prior to age 60, either as a result of disease or injury and where such disability is continuous for a period of six or more consecutive months, $5.00 per month for each $1,000 of insurance is provided under the disability provision. This income would be payable as long as disability continued even beyond age 60, and is not deducted from the face amount of the contract.

At age 35 on the Five Year Level Term contract, the annual premium for the disability coverage on $10,000 contract is only $14.20 per year, which would provide in addition to waiver of premiums in the event of total disability a monthly income of $50.00 per month. At the same age, the rate applicable to Ordinary Life or Endowment at the age 60 or 65 contract for $10,000 would be $35.60. These rates are substantially below the cost of comparable coverage with a private company, so where a member desires any additional non-cancellable disability income this option certainly should be taken advantage of.

Any member of the O.S.M.A. who would like to apply for these benefits can write Oklahoma State Medical Association Insurance Trust, 1240 First National Building, Telephone FO 5-1456, Oklahoma City, and specific rates and the firm involved will be gladly furnished, or such can be secured direct from any Veterans Bureau office.

CLASSIFIED ADS

OFFICE SPACE for lease. Ten rooms, two lavatories, private parking, air conditioned, ground floor. Will rent half or lease all. 1225 North Walker or call FOrest 5-4842 or TR 8-3311.

FOR SALE: Complete office equipment and furniture, including x-ray and bucky (2 yr. old) for General Practitioner. May be bought on easy terms. Excellent opportunity for practice in town of 4,500. Long term lease on desirable office space available at low rent. If interested write for complete invoice of equipment, and details of opening for practice. R. O. Smith, M.D., 306 N. Willow, Fayetteville, Arkansas.

FOR SALE: Physician's instruments and office equipment. Mrs. Melvin Fry, 2007 S.W. 15, Oklahoma City, Okla. Phone CEntral 2-9284.

WILL BUILD TO SUIT PHYSICIAN. Plan your own office in building to be shared with Oklahoma City dentist. Choice location, 827 N.W. 10th. For details call CE 2-0000.

GENERAL PRACTICE OPPORTUNITY: Stuart, Oklahoma; to serve trade area of 1,500; partially equipped office available; good church town, new school; contact Robert Lee Nunn, Postmaster.

WANTED General Practitioner to give anesthetic in private clinic. Please advise qualifications in first letter. Box D, c/o THE JOURNAL, P. O. Box 9696, Shartel Station, Oklahoma City, Okla.

FOR SALE: Hamilton steelstone suite; mist green color. Consisting of examining table, treatment cabinet, waste receptacle, and stool. Also miscellaneous instruments for general practice use. All in excellent condition, less than two years old. Quentin T. Brooks, M.D., Western State Hospital, Ft. Supply, Oklahoma.

WANTED: Physicians, American Graduates for State Mental Hospital. Training Psychiatric preferred but not essential. Re-organized hospital; some housing available at nominal cost. Institution located in resort area. Good transportation adjacent Tulsa. Beginning salary $10,000-$12,000 depending upon experience. Write Box A, c/o THE JOURNAL, Oklahoma State Medical Association, P.O. Box 9696, Shartel Station, Oklahoma City, Oklahoma.

University of Oklahoma School of Medicine Announces Internship Appointments for 1957 Graduates

The following is a list of internship appointments of the 1957 graduates of the University of Oklahoma School of Medicine.

Name	Hospital	Location
Abbott, Mary I.	Mercy Hospital	Oklahoma City, Okla.
Bagwell, Kenneth H.	St. John's Hospital	Tulsa, Okla.
Barbee, Richard F.	Mercy Hospital	Oklahoma City, Okla.
Bird, Billy J.	Veterans Adm. Hospital	Oklahoma City, Okla.
Bliss, Bryce O.	St. John's Hospital	Tulsa, Okla.
Boles, Gerald W.	St. Anthony Hospital	Oklahoma City, Okla.
Braden, Barbara F.	Univ. of Oklahoma Hospitals	Oklahoma City, Okla.
Braden, Donald K.	Univ. of Oklahoma Hospitals	Oklahoma City, Okla.
Brown, Charles R.	Mercy Hospital	Oklahoma City, Okla.
Burr, John C.	Denver General Hospital	Denver, Colorado
Bynum, Chester L.	Mercy Hospital	Oklahoma City, Okla.
Coats, Jack L.	St. John's Hospital	Tulsa, Okla.
Compton, A. Paul	St. John's Hospital	Tulsa, Okla.
Cornelius, George R.	St. Anthony Hospital	Oklahoma City, Okla.
Crabtree, James A.	Los Angeles County Hospital	Los Angeles, Calif.
Dolenz, Bernard J.	Boston City Hospital	Boston, Mass.
Durham, Wilson E.	St. John's Hospital	Tulsa, Okla.
Dycus, Don L.	St. John's Hospital	Tulsa, Okla.
Ellis, Robert K.	Gorgas Hospital	Panama Canal Zone
Gebetsberger, Charles	Military Service	
Goodman, Thomas A.	George Washington U. Hosp.	Washington, D. C.
Green, James D.	St. John's Hospital	Tulsa, Okla.
Haddad, George N., Jr.	Jackson Memorial Hospital	Miami, Florida
Hewett, Horace E.	St. John's Hospital	Tulsa, Okla.
Holley, Paul S.	Univ. Kansas Med. Center	Kansas City, Kansas
Hood, John W.	Univ. Minnesota Hospital	Minneapolis, Minn.
Hope, Sherman A.	U. S. Air Force, Fitzsimmons Army Hospital	Denver, Colorado
Hubbard, Floyd T.	St. Anthony Hospital	Oklahoma City, Okla.
Hughes, William L.	Univ. of Virginia Hospital	Charlottesville, Va.
Hummer, Lloyd M.	George Washington U. Hosp.	Washington, D. C.
Jayne, Howard	Wesley Hospital	Oklahoma City, Okla.
Johnson, Richard B.	Parkland Hospital	Dallas, Texas
Jones, O. W., Jr.	Duke Hospital	Durham, North Carolina
Kalbfleisch, John M.	Univ. of Virginia Hospital	Charlottesville, Va.
Kearns, Harry J., Jr.	St. Anthony Hospital	Oklahoma City, Okla.
Keith, Howard B.	Univ. of Oklahoma Hospitals	Oklahoma City, Okla.
Kennedy, Willard C.	Univ. of Oklahoma Hospitals	Oklahoma City, Okla.
Kobs, Tracy L.	George Washington U. Hosp.	Washington, D. C.
Kouri, Sammy H.	Wesley Hospital	Oklahoma City, Okla.
Lambiotte, Benjamin J.	The Lankenau Hospital	Philadelphia, Pa.
Lang, Frederick L.	Mercy Hospital	Oklahoma City, Okla.
Livingston, David E.	St. Anthony Hospital	Oklahoma City, Okla.
Mackler, David L.	San Francisco Hospital, (Stanford Service)	San Francisco, Calif.
Martin, Fred R.	Detroit Receiving Hospital	Detroit, Michigan
McArthur, Lloyd G.	Military Service	
McGinnis, Delbert H.	The Queen's Hospital	Honolulu, Hawaii
Medcalf, Winfred L.	Mercy Hospital	Oklahoma City, Okla.
Meinhardt, Kenneth	Gorgas Hospital	Panama Canal Zone
Mings, Harold H.	Parkland Hospital	Dallas, Texas
Nash, Howard L.	Univ. of Oklahoma Hospitals	Oklahoma City, Okla.
Neal, Victor R.	St. Anthony Hospital	Oklahoma City, Okla.
O'Bar, Paul R.	Bellevue Hospital, (Columbia Division)	New York, New York
Orbin, Johnnie A.	St. Anthony Hospital	Oklahoma City, Okla.
Park, Riley W., Jr.	Emanuel Hospital	Portland, Oregon
Paul, Roger R.	St. John's Hospital	Tulsa, Okla.

Payte, James T.	Santa Rosa Hospital	San Antonio, Texas
Peter, Maurice L., Jr.	St. Anthony Hospital	Oklahoma City, Okla.
Peterson, Robert F.	Wesley Hospital	Oklahoma City, Okla.
Phillips, Donald M.	Univ. of Calif. Hospital	Los Angeles, Calif.
Price, King G.	Boston City Hospital	Boston, Mass
Reimer, J. Paul	U. Texas Med. Br. Hospital	Galveston, Texas
Riley, Lee H., Jr.	Johns Hopkins Hospital	Baltimore, Maryland
Rinn, Odville Alton	Santa Rosa Hospital	San Antonio, Texas
Ritan, John L.	Univ. of Oklahoma Hospitals	Oklahoma City, Okla.
Robinson, Charles W.	Univ. of Minnesota Hosp.	Minneapolis, Minn.
Savage, William L.	St. Anthony Hospital	Oklahoma City, Okla.
Shibley, George J.	Scranton State Hospital	Scranton, Pa.
Siddons, Ivan D.	U. Texas Med. Br. Hospital	Galveston, Texas
Simon, Robert B.	Presbyterian Hospital	Denver, Colorado
Smith, Bradley E.	U. S. Navy Hospital	St. Albans, New York
Smith, Gene R.	St. Anthony Hospital	Oklahoma City, Okla.
Smith, John R.	St. Vincent's Hospital	New York, New York
Smth, William O., Jr.	Kansas U. Medical Center	Kansas City, Kansas
Sprehe, Daniel J.	Charity Hospital	New Orleans, La.
Stansberry, Cecil R.	Mercy Hospital	Oklahoma City, Okla.
Stephenson, Jack M.	St. Anthony Hospital	Oklahoma City, Okla.
Steward, Rodney D.	St. Anthony Hospital	Oklahoma City, Okla.
Sullivan, Jerry W.	Baptist Memorial Hospital	Memphis, Tennessee
Talley, John E.	St. Luke's Hospital	Denver, Colorado
Thurston, Thomas W.	St. John's Hospital	Tulsa, Okla.
Vann, Paul N.	Public Health Service	Norfolk, Virginia
Vaughn, Thomas N.	Univ. of Oklahoma Hospitals	Oklahoma City, Okla.
Walters, Philip G.	Presbyterian Hospital	Denver, Colorado
Watkins, Wanda L.	Univ. of Oklahoma Hospitals	Oklahoma City, Okla.
Webb, Floyd E., Jr.	Cincinnati General Hospital	Cincinnati, Ohio
White, Wayne F.	Pierce County Hospital	Tacoma, Washington
Winn, Donald A.	Mt. Zion Hospital	San Francisco, Calif.
Yates, Loren K.	Santa Rosa Hospital	San Antonio, Texas

O.S.M.A. to Be Represented At A.M.A. P.R. Institute

Five persons will represent Oklahoma at the American Medical Association's Public Relations Institute to be held in Chicago August 28 and 29, 1957. From the State Office will be E. C. Mohler, M.D., Ponca City, President-Elect; A. T. Baker, M.D., Durant, Vice-Chairman of the Public Policy Committee; and Dick Graham, Executive Secretary. Representing the Tulsa County Medical Society will be Executive Secretary Jack Spears. The Blue Shield Plan of Oklahoma will send Carl Behle, Director of Professional Relations.

An annual affair, the Institute provides and opportunity for the exchange of medical public relations ideas and information. Leading off the meeting will be two panel discussions on medicine and publicity. Roland Berg of *Look* magazine, scrience writer John Troan of Pittsburg, and newsman Bob Clark of Louisville are among the participants. An entire afternoon will be devoted to workshop-type discussion sessions of public relations problems of large and small state and county societies. Thursday morning's program includes a case history-type re-evaluation of grievance committee operations and a review of socio-economic and legislative problems facing medicine with suggestions for solving them.

Death

DANIEL PHILLIP RICHARDSON, M.D.
1869-1957

Daniel Phillip Richardson, M.D., died in his home in Union City on July 15 at the age of 88.

Doctor Richardson, who also had a very successful career in banking, was born May 4, 1869, at Alanthus, Missouri. He was graduated from Louisville Medical School at Louisville, Kentucky, in 1894 and moved to Union City 63 years ago.

Doctor Richardson was an honorary member of the Oklahoma State Medical Association.

Coming Meetings

HILLCREST MEDICAL CENTER
1653 East 12th St., Tulsa, Okla.

Lectures in Basic Science Given by Faculty Members of the University of Oklahoma School of Medicine.

Aug. 13—Porphyrins, porphyrinuria, etc., E. G. Larsen, Lecturer.

Aug. 27—Bone metabolism: osteoporosis. etc., A. A. Hellbaum, Lecturer.

Sept. 10—Recent Advances in Oncology, W. E. Jacques, Lecturer.

Sept. 24—Recent Advances in Viral Diseases of the respiratory System, L. V. Scott, Lecturer.

Oct. 8—Basic medical psychology, L. J. West, Lecturer.

Oct. 22—Heart Function: cardiac reserve, A. N. Taylor, Lecturer.

Nov. 12—Common Spinal Pathways, G. H. Daron, Lecturer.

Nov. 26—Cerebellar Structures and Function, G. H. Daron, Lecturer.

Dec. 10—Autonomics: Structure and Function, G. H. Daron, Lecturer.

Dec. 17—Central Autonomic Function as related to common medical diseases, C. G. Gunn, Lecturer.

POSTGRADUATE SHORT COURSE
OU MEDICAL SCHOOL
September 11, 1957

A postgraduate short course will be held September 11, 1957, from 3:30 to 8:30 p.m. in room 118 at the University of Oklahoma School of Medicine.

The subject for the afternoon and evening sessions will be "Congestive Heart Failure." Guest speaker will be Richard V. Ebert, M.D., of the University of Arkansas School of Medicine.

SOOUTHWESTERN CANCER CLINIC
September 20 and 21, 1957
Ft. Worth, Texas

The Southwest Regional Cancer Conference will be held September 20 and 21, 1957, in Fort Worth, Texas, with headquarters in the Texas Hotel.

Speakers for the meeting will be: Dr. Mark M. Ravitch, Baltimore; Dr. John D. Reeves, Boston; and Dr. Thomas M. Peery, Washington, D.C.

Oklahoma Chapter of the
AMERICAN COLLEGE OF SURGEONS
September 27-28, 1957

A meeting of the Oklahoma Chapter of the American Cillege of Surgeons will be held at the Western Hills Lodge at Sequoyah State Park on September 28 and 29, 1957.

The Scientific Program will consist of the winning papers selected from the Oklahoma Association of House Staff Physicians presented at their annual meeting in May, 1957. The papers which will be presented are as follows:

AN EPIDEMIC OF BREAST ABSCESSES
—Robert W. Dean, M.D., St. Johns Hospital, Tulsa

SPLENECTOMY FOR CONGENITAL HEMOLYTIC ANEMIA
—Robert Jabour, M.D., Hillcrest Medical Center, Tulsa

EXCISION OF INTERNAL CAROTID ANEURYSM EMPLOYING HYPOTHERMIA AND VASCULAR SHUNT—IN PREGNANT WOMEN (PATIENT IN FIRST TRIMESTER OF GESTATION)
—Karl K. Boatman, M.D., Oklahoma City

CHLORPROMAZINE AS A MASKING AGENT IN INTESTINAL OBSTRUCTION
—Duane A. Barnett, M.D., Ponca City

THE FUNCTIONING CARCINOID SYNDROME
—William R. McCabe, M.D., University of Oklahoma Medical Center, Oklahoma City

STUDIES OF POST-PARTUM PITUITARY NECROSES
—Carl Smith. M.D., University of Oklahoma Medical Center, Oklahoma City

For further information write the post graduate office of the Oklahoma Medical Center, 800 N.E. 13th Street, Oklahoma City, Oklahoma.

PHYSICIAN PLACEMENT

Anesthesia

Daniel B. Perry, Residence Quarters, Harlem Hospital, New York, N. Y., age 48, Meharry Medical College, 1948, interned at Harlem Hospital, New York and served residency in anesthesia there, veteran, available December, 1957.

General Practice

Louis Marshall Cuvillier, Jr., 1407 Woodside Parkway, Silver Spring, Maryland, age 44, married, George Washington University School of Medicine, 1938, interned at Garfield Memorial Hospital, Washington, D.C., one year residency in medicine and obstetrics at Norfolk General Hospital, Norfolk, Virginia. Veteran, available upon 90 day notice.

Orby L. Butcher, Jr., 3106 Alaska, Dallas, Texas, age 29, married, University of Oklahoma, 1955, now in surgical residency at VA Hospital in Dallas, Veteran. Available, July, 1957.

David L. Mossman, USAH, Orthopedic Department, Ft. Riley, Kansas, age 28, married, University of Vermont, 1954, available upon separation from service, December, 1957.

Robert R. Rupp, 1235 N. Lorraine, Wichita, Kansas, age 30, married, University of Oklahoma, 1956, internship at Wesley Hospital, Wichita, veteran, available, July 1, 1957.

Internal Medicine

Rensselaer, W. M.Clure, Mayo Foundation, Rochester, Minnesota, age 31, married, University of Kansas, 1948, veteran, available July 1, 1957.

James E. Morris, Jr., 1034 Second St., S.E., Moultrie, Georgia, age 26, married, University of Tennessee College of Medicine, 1953, one year internal medicine residency, now serving military obligation, available February, 1957.

Robert W. Datesman, 94 Oak Street, Westwood, Massachusetts, age 30, married, University of Pennsylvania, 1951, residency training at University of Minnesota Hospitals, and Boston Veteran Hospital, Veteran, available in July, 1957.

Joseph A. Ezzo, 3215 Nebraska, St. Louis 18, Missouri, age 32, married, St. Louis University, residency at St. Louis City Hospital and St. Louis University Hospitals, veteran, available, July 1, 1957.

Obstetrics-Gynecology

John P. Harrod, Jr., 932 E. 56th Street, Chicago 37, Illinois, age 33, married, University of Georgia, 1946, served residency at University Hospital, Augusta, Ga., Duval County Hospital, Jacksonville, Florida and at Chicago Lyons-In Hospital, Board certified, veteran, availability date unkown.

Bernard Martin Davis, Jr., 101 Turnbridge Rd., Baltimore 12, Maryland, age 31, married, Georgetown University, 1951, 3 years residency at University Hospital, Baltimore, veteran, available, July 1, 1957.

Pediatrics

Robert W. Mosely, 211 Adams Street, Galax, Virginia, age 32, married, Medical College of Virginia, 1948, residency at Walter Reed Army Hospital, Board eligible, interested in private practice or public health, veteran, available April, 1957.

Surgery

Aristides Cardona, 106 Sinis Rd., Syracuse, New York, age 30, married, State University of New York, 1951, Board eligible, wants additional residency, veteran, available, June, 1957.

Vernon L. Guynn, 2026 S. Second Ave., Maywood, Ill., age 32, married, University of Illinois, 1947, passed Part I of General Surgery Board, military obligation served, available January 1, 1957.

Alvin S. Natanson, 49 Kiernan Drive, Rantoul, Illinois, age 36, married, Tufts Medical College, 1949, residency training at Boston City Hospital, Diplomate of the American Board of Surgery, available upon separation from service, July, 1957.

James Firth Alexander, Charity Hospital, New Orleans, Louisiana, age 34, single, Ohio State, 1949, in orthopedic residency training now, veteran, available immediately.

Karl Edwin Blake, 2681 Crosby Avenue, Pittsburgh 16, Pa., age 33, married, University of Pittsburgh, 1948, residency at VA Hospital and Children's Hospital, Pittsburgh, Board Eligible, veteran, available May, 1957.

Urology

John C. Brazos, 406 South Washington, Watertown, Wisconsin, age 36, married, University of Illinois, 1949, interned at Anckee County Hospital, St. Paul, Minnesota, residency at Milwaukee County Hospital, Milwaukee, Wisconsin. Veteran, available upon completion of residency, July 31, 1957.

Paul Lucian Livingston, 18340 Lake Chabot Road, Castro Valley, California, age 35, married, New York Medical College, 1946, served residencies at Orange Memorial Hospital, New Jersey and at Veterans' Administration Hospital, Long Beach, California, now Assistant Chief Urologist at V.A. Hospital, Board Qualified, veteran, available upon sixty days notice.

CALIFORNIA STATE

assignments for

PHYSICIANS AND PSYCHIATRISTS

Three Salary Groups:
$11,400-12,600
.12,000-13,200
.13,200-14,400

Streamlined employment procedures — interview only. U.S. citizenship and possession of, or eligibility for California license required.

Write: Medical Recruitment Unit, Box A, State Personnel Board, 801 Capitol Ave. Sacramento, California

25 YEARS AGO

Articles published in *The Journal* of the Oklahoma State Medical Association August, 1932. Edited by John C. Matt, M.D., Tulsa.

DIPHTHERIA

George H. Garrison, A.B., M.D.
Oklahoma City

"This discussion is intended to bring before us certain practical points encountered in the diagnosis and treatment of diphtheria. For the five year period ending December 31, 1931, diphtheria was given as the cause of death in Oklahoma one thousand five hundred and sixty-seven times, (1567), and average of 321 each year. While we may rightfully expect a marked reduction in both the incidence and the mortality due to this disease during the next five years as a result of the increased effort toward universal immunization of susceptible individuals, it deserves some consideration now.

Kinnamann of Kansas makes this significant statement, "we have observed in Kansas that diphtheria is apparently of a more virulent type as the number of immunized children is increased. Immunized carriers pass diphtheria organisms of a virulent type to the non-immunized child with the result that the case-fatality-rate is increasing each year among the non-immunized children who contract diphtheria." Whether Kinnamann's explanation of this increased case-fatality-rate is entirely correct or not, such observations should serve to make us more determined to immunize all susceptible persons and put us on guard lest we err in the recognition of diphtheria . . .

Antitoxin

There is wide variation in the dose of antitoxin recommended in the treatment of diphtheria. It will ordinarily be considered sufficient to give 5000 to 10,000 units of antitoxin in early cases and those of moderate extent. In severe and toxic cases, especially if of several days duration, a dose of 10,000 to 20,000 units should be given with the larger dose receiving preference. Whatever dose has been decided upon it should be given at one time, though part of it may be administered by different routes, i.e. intramuscularly, intravenously or intraperitoneally, but not subcutaneously, because of slow absorption. A skin test for sensitization to the serum is advisable as a routine before injecting antitoxin and it is imperative that it be done before giving antitoxin into the vein. Quite often it will be observed that the visible membrane is even greater in extent 18 to 24 hours after injection and it is this which causes physicians to give a second injection of antitoxin. It appears that this increase in the size of the membrane will usually occur regardless of the amount of antitoxin orginally given. Diphtheria membrane requires time to develop and the pathologic process had already been initiated over a definite area before antitoxin was given and 'simply goes on to completion . . . . . .

Carriers

A small percentage of persons recovering from diphtheria will become "carriers" of the bacillus. When local treatment to the nose and throat fails after a reasonable time to eradicate the organism, removal of the tonsils and adenoid tissue is usually successful in clearing up the condition.

Immunity

The degree of immunity which a patient develops as a result of diphtheritic infection is widely variable. Most individuals become permanently immune, some are immune for only one year or two years. If the immunity remains for two years, it will probably be permanent. It is essential then in view of the possibility of a loss of immunity after a period of time, that we advise every patient of this possibility and urge upon him the necessity for having a Schick test done after one year and after two years. If he should show a positive Schick, he should be immunized."

FIFTIETH ANNIVERSARY OF FIRST REMOVAL OF GALL-BLADDER: SOME IMPROVEMENTS OVER THE PAST

"The writer, a son of a physician, relative of many others of the same profession, recalls with interest the various progressive steps of medical and surgical advances, though, at the time hardly realizing 'what it was all about,' or the importance of the so-called new operations or endeavor. Among those recalled especially where the opening of the abdomen, in the then 'out West,' a most serious procedure, and, if successful, the making of the surgeon bold enough to undertake the work. All of these in Indian Territory, up to a certain time were performed in the face of grave emergency, that is, it was certain death if operation was not performed, and almost as certain if it was. A case is recalled where diagnosis of acute appendicitis was made on the first day, operation positively advised, and with equal obduracy refused; finally, when the patient decided he would be operated upon the surgeon refused to operate in the face of obvious wide-spread peritonitis, so the patient remained in bed for more than a month, for days death daily expected, but being Irish and full of resistence, by some freak of nature the enormously distended abdomen, with a respiration rate, due to pressure, unbelievably high, slowly subsided, the man got well without operation, of course, proving the surgeon wrong, and as not knowing what he was talking about. These freaks are occasionally seen by all men with more or less experience. Today we are concerned with the first operation for removal of the gall-bladder. Frankly decided upon in advance, worked out decision to do a cholecystectomy. This operation was performed by Carl Langenbuch,* then chief of the Lazaruskrankenhaus, Berlin, July 15, 1882. The article

does not state the various data, history, etc., simply that he removed a gall-bladder, and that the patient recovered. All over the world, it seems simultaneously men began to do operations which had up to then been considered unusually formidable or positively "taboo." As reports began to circulate from one country to another the aggregate data was digested, the weak spots noted and eliminated, and soon rules based upon sound reasoning began to be applied to surgical conditions until it would have seemed that the last word had been spoken. However, it seems that there is no "last word," there are constant changes, constant advances and improvements. I recall the day when it was "fashionable" in abdominal surgery to use not less than three to five gallons of sterile or some form of antiseptic solution in the abdomen, to wash out debris, pus, blood, or "what have you?" After a time this gradually gave way to absolutely dry moppings, for the same purpose. Now at times there is a happy medium; occasionally there is a case where solutions are used and justifiably, but they are rare. The good things of yesterday are cast aside or improved upon, the cold glare of scientific reasoning is applied and rationalism rules, or is supposed to rule every manouvre or procedure. It has been one long day of continuous improvement, however, since the July 15 when Langenbuch removed the gall-bladder, the death rate in many things has almost wholly disappeared, the morbidity rate has kept pace with other improvements, until some fatuously imagine that the "last word has been spoken," that there can be no further advances. A moment's reflection should show us, if we apply the history of past events that probably there will be improvements all along the line. Medicine today is full of baffling, unsatisfactory results from the best and most accepted treatment. Slowly there will be improvements in these until finally that which today appears so baffling and irritating will be a matter of ease, and we will turn to some other problem."
*Archives of Surgery, July 1932

Editorial Notes—Personal and General

"DR. JOHN F. PARK, McAlester, has returned from a trip visiting European Clinics . . . . . .

DR. AND MRS. F. G. DORWART, Muskogee, will spend a month in the hills on the Illinois River during September.

DR. R. M. HOWARD, Oklahoma City, was elected President of the American Goiter Association, at the last Annual Session held at Toronto. The convention will be held in Switzerland next year . . . . . ."

TREATMENT OF CARDIAC ARRHYTHMIAS

(Continued from Page 386)

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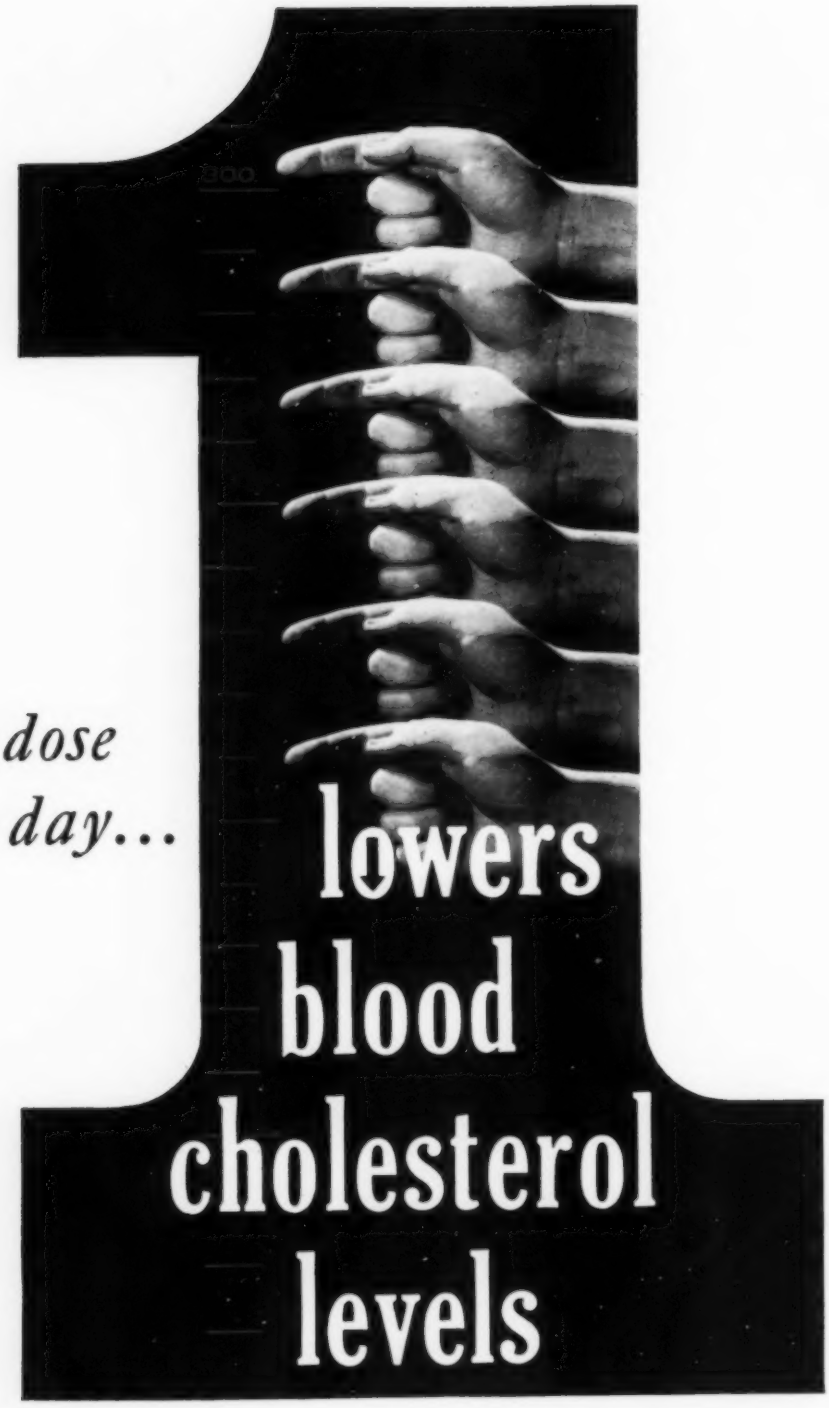
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